STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey: 10/9/20 CENSUS: 217 SAMPLE SIZE: 35 (plus 3 closed records) A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was also conducted. The facility is not in compliance with 42 CFR part 483 infection control regulations and did implement the CMS and Centers for Disease Control and Prevention (CDC) as recommended practices for COVID-19.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		10/12/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/29/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 1 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to develop a person-centered comprehensive care plan to address: a) an [REDACTED] for 1 of 3 residents (Resident#143); b) the use of [REDACTED] and [REDACTED] medications for 1 of 5 residents (Resident #199); and, c) update the care plan to address a change in [REDACTED] status for 1 of 5 residents (Resident #199). This deficient practice was evidenced by the following:	F 656	" What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; 1: Resident #143- The care plan was updated to reflect the use of an [REDACTED] [REDACTED] The resident had no adverse effects due to this omission. 2: Resident #199- The care plan was updated to include the use of [REDACTED]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 656 Continued From page 2

1. On 10/01/20 at 10:01 AM and 10/5/20 at 8:25 AM, the surveyor observed Resident #143 lying in bed with an [redacted] contained in a [redacted] that was hung on the left side of the bed.

A review of the resident's Face Sheet, an admission summary, indicated that the resident had diagnoses which included but were not limited to [redacted]).

A review of the resident's individualized care plan revealed that no care plan was initiated for the resident's [redacted]

A review of the [redacted] Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status (BIMS) score of [redacted], which reflected that the resident's cognition was intact. The CMDS noted that Resident #143 had an [redacted]. The CMDS showed a diagnosis of [redacted].

On 10/6/20 at 11:19 AM, the Registered Nurse/Unit Manager (RN/UM) stated that it was her responsibility to initiate and update the resident's care plan. She further said that a [redacted] places the resident at risk for infection, and that "absolutely there should be a care plan for it." The RN/UM could not speak to why Resident
#143 had no care plan for an [redacted].

On 10/7/20 at 2:01 PM, the Director of Nursing (DON) informed the survey team in the presence

F 656

[redacted] medications. The update also included the change in weight bearing status. The omission had no adverse effects on the resident.

" How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

The facility will identify other residents having the potential to be affected by the same deficient practice by initiating and completing an audit of ten resident care plans. We have recognized that all residents have the potential of being affected by incomplete care plans. The audit was under the supervision and direction of the DON/designee. The audit demonstrated completed care plans for all ten residents.

" What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;

In-service education was provided to nursing staff regarding creating a proper care plan for each individual resident as evidence by verbal communication and return demonstration.

" How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The date for correction and the title of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 3 of the Licensed Nursing Home Administrator (LNHA) and the Assistant Director of Nursing (ADON) that Resident #143's [redacted] care plan should have been initiated when it was ordered. 2. On 10/1/20 at 10:21 AM, the surveyor observed Resident #199 seated in a wheelchair in their room, calm and quiet. The resident informed the surveyor that they were unable to walk and had limitations to their [redacted] due to a fall incident from home 3 to 5 months earlier. On 10/5/20 at 10:33 AM, the Licensed Practical Nurse (LPN) informed the surveyor that Resident #199 was alert with some forgetfulness and no unusual behavior. The LPN stated that the resident was on [redacted] medications with no adverse effect. She further noted that the resident required extensive to total assistance with activities of daily living (ADLs) due to [redacted]. A review of the resident's Face Sheet indicated that the resident had diagnoses which included but were not limited to [redacted]. A review of the [redacted] CMDS revealed a BIMS score of [redacted], which indicated that the resident's cognition was intact. The CMDS noted that Resident #199 received [redacted] medications. A review of the October 2020 Order Summary Report (OSR) indicated an order for	F 656	person responsible for correction of deficiency Twelve care plan audits per quarter will be conducted by the DON / designee for 6 months. The results of the audit will be reviewed with the Administrator quarterly at the QA meeting for 1 year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 4	F 656		

medications dated for) one tablet (tab) by mouth (po) at and mg one tab po every 6 hours as needed for for 2 months.

Further review of the October 2020 OSR revealed an order dated for as tolerated (WBAT) to the

A review of the medical record revealed no individualized care plan was initiated for the use of medications.

Further review of the personalized care plan showed an intervention for no (N) to the The medical record indicated that the care plan for status was not updated to reflect the above order for .

On 10/6/20 at 11:44 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) informed the surveyor that it was her responsibility to oversee the initiation of the care plan, revision, and updating when there's a change in resident's condition and orders. She stated that the care plan for Resident #199 for the use of medications should have been initiated. She further noted that the care plan for NWB to the should have been updated to reflect the new order for to the

On that same date and time, the LPN/UM further stated, "I don't know why the care plan was not updated."

On 10/6/20 at 2:01 PM, the Regional Nurse, in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 5 the presence of the LNHA, DON, and the ADON, informed the survey team that the [redacted] care plan should have been initiated for Resident #199 and the [redacted] status should have been updated. The Regional Nurse stated that there was no specific care plan policy with regards to updating the [redacted] status. On 10/9/2020 at 11:15 AM, there was no further information provided by the facility. A review of the facility's Updating the Care Plan Policy with a revised date of 12/2019, provided by the LNHA, reflected that "The care plan shall be used in developing the resident's daily care routines, will be updated when changes occur and will be available to staff personnel who have responsibility for providing care or services to the resident." NJ 8:39-11.2 (e)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of clinical practice by not accurately transcribing a physician's order for 2 of 35 residents (Resident #126 & # 199) reviewed. This deficient practice was evidenced by the	F 658	" What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; 1: Resident #126- The primary physician was contacted to initiate corrective action. A new order was obtained to	10/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 658

Continued From page 6
following:

Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

1. On 10/1/20 at 09:00 AM, the surveyor, observed Resident #126 lying in bed.

The surveyor reviewed Resident #126's medical record. The resident was admitted to the facility on [redacted] with a diagnosis of [redacted] A review of the October 2020 Physician's Order (PO) revealed a PO dated [redacted] for [redacted] m[redacted] mg [redacted] every 4 hours for [redacted] hold for [redacted].

On 10/1/20 at 9:00 AM, during the medication observation pass, the surveyor observed a Licensed Practical Nurse (LPN) preparing to administer medications to Resident #126. The LPN pulled out a bottle of [redacted] and drew up [redacted] from a syringe that came with the bottle of [redacted] The surveyor stopped the nurse prior to administering the medication. The surveyor and LPN reviewed the Electronic Medication Administration Record (EMAR) for Resident #126. The EMAR order indicated [redacted]

F 658

correct the [redacted] order using the appropriate unit of measure.

2: Resident #199- The primary physician was notified of missing supplemental documentation needed to address [redacted] and [redacted] ordered parameters for the [redacted] medication [redacted] Supplemental documentation was added to the order.

" How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

To identify other residents having the potential to be affected by the same deficient practice an audit of supplemental documentation regarding [redacted] medications was completed. We recognize that this deficient practice can potentially affect all residents. The audit was done by the DON/designee and concluded no further transcription errors regarding supplemental documentation. An additional audit concluded that transcription of proper dosages regarding units of measure were correct.

" What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;

In-service education was provided to the nursing staff regarding order transcription,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 658

Continued From page 7

[redacted] to administer [redacted] every 4 hours as needed for [redacted] hold for [redacted]. The LPN then reviewed Resident #126's medical chart, which revealed a handwritten order for [redacted] every 4 hours for [redacted] hold for [redacted].

On 10/1/20 at 9:20 AM, the surveyor interviewed the LPN, who stated that the order was correct. However, a transcription error occurred while transferring the order from a written order into the facility's electronic system. The LPN acknowledged that the order should have been clarified with the physician.

On 10/5/20 at 1:00 PM, the surveyor presented the transcription error concern to the Director of Nursing and the Administrator.

A review of the facility's policy titled Medication and Treatment Orders did not address transcribing orders into the facility computer system.

2. On 10/1/20 at 10:21 AM, the surveyor observed Resident #199 seated in a wheelchair in their room.

A review of the resident's Face Sheet disclosed that the resident had diagnoses which included but were not limited to [redacted].

A review of the [redacted] Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status (BIMS) score of

F 658

parameters and the use of supplemental documentation. The risks were also included in the in-service.

" How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The date for correction and the title of the person responsible for correction of deficiency

The corrective action will be monitored by DON/designee along with the assistance of the pharmacy consultant by auditing five charts weekly for 3 months followed by two charts weekly for 3 months. This practice will ensure all orders are transcribed properly with the appropriate unit of measure, dosage, parameters, and supplemental documentation as needed. Results of the audit will be reviewed with the Administrator quarterly at the QA meeting for 6 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 8	F 658		

, which indicated that the resident's cognition was intact.

A review of Resident #199's October 2020 Order Summary Report (OSR) showed an order dated (mg) one tablet (tab) by mouth two times a day for hold for and

The corresponding physician's order was transcribed into the resident's October 2020 electronic Medication Administration Record (eMAR) and signed by the nurses as administered each day. There was and recorded in the October 2020 eMAR for when the medication was administered.

On 10/6/20 at 11:29 AM, the Licensed Practical Nurse (LPN) informed the surveyor that Resident #199 was on and should be held when . The LPN stated that she held the medication "today" because the resident's

On that same day and time, the LPN was unable to show to the surveyor that the was documented in the eMAR. She stated that the order for was not properly carried over to the eMAR to include an area on eMAR to document the per physician's order. She further stated that "it was probably missed."

At that time, the LPN showed the surveyor a piece of paper with a list of . The LPN stated she obtained the resident's blood pressure of "this morning." She indicated that the eMAR order for should have included the and according to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 9 physician's order. On 10/6/20 at 1:02 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Regional Nurse and discussed the above observations and concerns. On 10/7/20 at 2:01 PM, the DON, in the presence of the LNHA, and ADON informed the survey team that Resident #199's order for Coreg, when changed on [redacted], did not include the supplemental documentation for [redacted] according to the physician's order when transcribed into the eMAR and that was why it was missed. A review of the facility's policy for Medication and Treatment Orders provided by the LNHA with a revised date of [redacted] reflected that: "orders for medications and treatments will be consistent with principles of safe and effective order writing," and "any interim follow-up requirements (pending [redacted] reports, [redacted] [redacted], therapeutic medication monitoring, etc)." NJAC 8:39-11.2 (b) NJAC: 8-39-27.1 (a)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		10/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 10 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain the necessary respiratory care and services of a resident who was receiving [redacted] and [redacted] according to the standard of practice. This deficient practice was identified for 1 of 2 residents (Resident #34) and was evidenced by the following: On 10/1/20 at 9:58 AM, the surveyor observed Resident #34 seated in a wheelchair with a [redacted] machine on top of the resident's bed and [redacted] in use at [redacted] that was attached to a [redacted]. The resident stated that they used [redacted] and had a [redacted] treatment given by a nurse that morning. On 10/1/20 at 12:29 PM, the surveyor observed the resident seated in a wheelchair with 3 LPM of oxygen via NC in use. Resident #34 informed the surveyor that they have been on [redacted] and using a [redacted] for more than [redacted] at home before being transferred to the facility. On that same day and time, Resident #34 stated, "[redacted]." The resident was unable to remember the nurse who set the [redacted] The resident said that he/she only turns the [redacted] on or off, but the nurse sets the [redacted]. The resident further stated that "it was the Licensed Practical Nurse (LPN) who administered the [redacted] treatment today."	F 695	" What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; 1: Resident #34- The primary physician was notified of resident receiving [redacted] [redacted] per order. The physician also discontinued the previous titration order. There were no adverse reactions due to this deficient practice. 2: Resident #34- The primary physician was contacted and an order was provided for [redacted] treatments. There were no adverse reactions due to this deficient practice. " How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; An audit of ten resident medication records was completed to identify other residents having the potential to be affected by the same deficient practice. We recognize that all residents receiving [redacted] treatment have the potential of being affected. " What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 695

Continued From page 11

On 10/5/20 at 8:35 AM and 10/6/20 at 11:03 AM, the surveyor observed the resident with [redacted] in use at [redacted]

A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to [redacted]

A review of the [redacted] Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status (BIMS) score was [redacted] which indicated that the resident's cognition was intact. The CMDS noted that the resident was on [redacted].

A review of the resident's personalized care plan for as needed (PRN) [redacted] therapy initiated on [redacted] revealed an intervention for [redacted]

Further review of the resident's personalized, comprehensive care plans revealed a care plan for [redacted] initiated on [redacted] with interventions to give [redacted] as ordered.

The surveyor reviewed the October 2020 Order Summary Report (OSR), which revealed a physician's order dated [redacted] for PRN [redacted].

F 695

recur;

In-service education was provided to the nursing staff regarding the need for a physician□s order prior to administering medications or treatments, and the need to ensure that [redacted] is administered at the [redacted] in the physician□s order. This measure was put in place to ensure the deficient practice does not recur.

" How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The date for correction and the title of the person responsible for correction of deficiency

The corrective action will be monitored by the DON/designee through an audit of five resident medication records and observation of same residents for 3 months followed by two for 3 months to ensure physician orders match the [redacted] treatment being administered by the nurse. Results of the audit will be reviewed with the Administrator quarterly at the QA meeting for 6 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 12	F 695		

Further review of the October 2020 OSR showed that there was no order for [redacted] treatment.

The corresponding physician order for PRN oxygen was transcribed into the resident's electronic Treatment Administration Record (eTAR) for October 2020. The PRN [redacted] order in the eTAR reflected that [redacted] was administered when observed in use on the following dates: 10/1/20, 10/5/20, and 10/6/20.

On 10/6/20 at 11:03 AM, the LPN informed the surveyor that Resident #34 was on [redacted] as ordered by the physician" [redacted] The LPN also stated that the resident was cognitively intact.

On that same date and time, the surveyor and the LPN observed the resident lying in bed in their room utilizing [redacted]. The LPN confirmed that the resident was receiving [redacted], not [redacted], as per the physician's orders and acknowledged that the eTAR was not signed off as administered, but the [redacted] was administered.

At that time, the surveyor interviewed the LPN after exiting the resident's room. The LPN stated, "I don't know why there isn't an order for [redacted]." The LPN confirmed no other order for [redacted], except for the PRN [redacted] The LPN could not explain why the [redacted] was set [redacted] and why there was no physician order for the [redacted] treatment and why it was being administered without a physician's order.

Furthermore, the LPN stated that there was no adverse effect on the resident and that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 13	F 695		

resident tolerated the [redacted] treatment. The LPN further noted that the order should have been clarified.

On 10/6/2020 at 2:01 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant Director of Nursing (ADON), and the Regional Nurse and discussed the above observations and concerns.

On 10/7/2020 at 2:01 PM, the DON, in the presence of the LNHA and the ADON, informed the survey team that Resident #34 should have been getting [redacted] according to the physician's order. The DON further stated that the neb treatment should not have been administered without a physician's order.

On 10/8/20, at 1:42 PM, the survey team met with the LNHA, DON, ADON, and the Regional Nurse. The DON informed the surveyor that after investigation, the LPN had administered the neb treatments without a physician order. The DON stated that there was no adverse effect on the resident. She further noted that because of the incident, the LPN was disciplined.

A review of the [redacted] Administration Policy with a revised date of 12/2019, provided by the LNHA indicated "Verify that there is a physician's order for this procedure ...Review the physician's order or facility protocol for [redacted] administration," and "Report other information in accordance with facility policy and professional standards of practice."

A review of the [redacted] Administration Policy with a revised date of 12/2019, provided by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 14 LNHA, showed that "Verify that there is a physician's order for this procedure." NJAC 8:39-11.2 (b); 27.1(a)	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a medication error rate below 5%. The surveyor observed 7 nurses administered 25 medications to 10 residents with 2 errors that resulted in a medication error rate of 8%. This deficient practice was evidenced by the following: On 10/1/20 at 9:30 AM, the surveyor observed a Licensed Practical Nurse (LPN) administered mg, mg, mg, mg, mg, and) to Resident #24. The surveyor reviewed the cautionary printed on the medication packaging card for mg, which indicated, ." The surveyor reviewed Resident #24's medical record. The resident was admitted to the facility	F 759	" What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; 1: Resident #24- Pharmacy was contacted and the administration times of were changed to 11am and 8pm. This change will ensure is given 2 hours prior as recommended by the pharmacy. No adverse reactions were noted due to this deficient practice. 2: Resident #24- Pharmacy was contacted and the administration times of were changed to 11am and 8pm. This change will ensure that given 2 hours prior as recommended by the pharmacy. No adverse reactions were noted due to this deficient practice. " How you will identify other residents having the potential to be affected by the same deficient practice and what	10/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 759 Continued From page 15

on [redacted] with a diagnoses of Hypertension, [redacted]. A review of the October 2020 Physician's Order (PO) revealed a PO dated [redacted] for [redacted] mg 1 tablet by mouth two times daily for [redacted]

On 10/1/20 at 11:20 AM, the surveyor interviewed the LPN, who stated that she was unaware that [redacted] needed to be administered either two hours before or six hours after [redacted]

The surveyor reviewed the Manufacturer's Specifications for [redacted] mg, [redacted]), and [redacted] and noted the following:

1. [redacted] mg should be administered two hours before or six hours after [redacted]). ERROR #1

2. [redacted] mg should be administered two hours before or six hours after [redacted]. ERROR #2

On 10/1/20 at 11:30 AM, the surveyor interviewed the Unit Manager, who checked the Manufacturer's Specifications on her computer. The Unit Manager stated that the [redacted] should be administered either 2 hours before or six hours after [redacted].

On 10/5/20 at 1:00 PM, the surveyor discussed the above concerns with the Director of Nursing and the Administrator. No additional information

F 759

corrective action will be taken;

We identified other residents having the potential to be affected by the same deficient practice by conducting a medication pass with the pharmacy consultant, which included five nurses. We recognize that all residents have the potential of being affected by a medication error. The medication pass was completed by our pharmacy consultant concluding a rate below five percent.

" What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;

Nursing staff was provided an in-service on checking cautionaries prior to administering medications.

" How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The date for correction and the title of the person responsible for correction of deficiency

The corrective action will be monitored by the DON/designee and pharmacy consultant. Collectively, both parties will audit and review the medications of five residents weekly for 3 months followed by two for 3 months to ensure medication cautionaries are consistently followed. This practice will ensure deficient practice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 16 was provided. A review of the facility's policy titled Administrating Medications under #3. "Medications must be administered in accordance with the orders, including any required time frame." NJAC: 8:39-29.2 (d)	F 759	will not recur. Results of the audit will be reviewed with the Administrator quarterly at the QA meeting for 6 months.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		10/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 761

Continued From page 17

Based on observation, interview, and record review, it was determined that the facility failed to properly label and dispose of medications for 5 of 11 medication carts and 1 of 6 medication refrigerators inspected.

This deficient practice was evidenced by the following:

On 10/5/20 at 9:15 AM, the surveyor, in the presence of a Licensed Practical Nurse (LPN#1), inspected the [redacted] medication cart. The surveyor observed a bottle of [redacted] that was opened and not dated. The surveyor interviewed LPN #1, who acknowledged that the [redacted] bottle was opened and stated that it should have been dated.

On 10/5/20 at 9:30 AM, the surveyor, in the presence of the Unit Manager (UM), inspected the medication room refrigerator on [redacted] The surveyor observed an opened [redacted] with an opened date of 8/9/20 that was expired. The surveyor interviewed the UM, who stated that the [redacted] was discontinued and acknowledged that a discontinued medication should have been removed from the medication refrigerator.

On 10/5/20 at 9:40 AM, the surveyor, in the presence of LPN #2, inspected the [redacted] medication cart. The surveyor observed an opened and undated [redacted]. The surveyor interviewed LPN #2, who stated that an opened [redacted] vial should have been dated.

On 10/5/20 at 9:45 AM, the surveyor, in the presence of LPN #3, inspected the [redacted]

F 761

" What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice;

1: [redacted] - The opened and undated bottle of [redacted] was discarded.
2: [redacted] The expired [redacted] was discarded.
3: [redacted] - The opened and undated vial of [redacted] was discarded.
4: [redacted] - The opened and undated bottle of [redacted] was discarded.
5: [redacted] - The expired vial of [redacted] discarded.
6: [redacted] - The expired vial of [redacted] discarded.

" How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents have the potential of being affected by expired and/or undated medication. To identify other residents having the potential to be affected by the same deficient practice, all medications carts and refrigerators were checked by the pharmacy consultant as well as the unit managers. No other medications have been found expired or undated after opening.

" What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 18 medication cart. The surveyor observed an opened and undated bottle of [redacted] solution. The surveyor interviewed LPN #3, who stated that the opened bottle of [redacted] should have been dated. On 10/5/20 at 10:00 AM, the surveyor, in the presence of LPN #4, inspected the [redacted] medication cart. The surveyor observed an opened [redacted] with an expiration date of 10/4/20. The surveyor interviewed LPN #4, who stated that the expired [redacted] vial should have been removed from the medication cart. On 10/5/20 at 10:30 AM, the surveyor, in the presence of LPN #5, inspected the [redacted] medication cart. The surveyor observed an opened vial of [redacted] with an expiration date of 9/4/20. The surveyor interviewed LPN #5, who stated that the expired vial of [redacted] should have been removed from the medication cart. A review of the Manufacturer's Specifications for the above medications indicated the following: 1. [redacted], once opened, had an expiration date of [redacted]. 2. [redacted] vial, once opened, had an expiration date of [redacted]. 3. [redacted], once opened, had an expiration date of [redacted]. 4. [redacted], once opened, had an expiration date of [redacted] A review of the facility's policy titled Medication Storage indicated the following under 4. "The facility shall not use discontinued, outdated, or	F 761	The pharmacy consultant will audit all medication carts and refrigerators monthly to ensure proper labeling and storage is maintained on all six units to prevent this deficient practice. Nursing staff were provided an in-service regarding facility policy on storage and labeling of medications. " How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The date for correction and the title of the person responsible for correction of deficiency The corrective actions will be monitored by the DON/designee by auditing all medications and refrigerators carts every two weeks for twelve weeks. This action will then continue monthly for three months to ensure that proper labeling and storage is maintained. Results of the audit will be reviewed with the Administrator quarterly at the QA meeting for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 19 deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed. NJAC: 8:39-29.4 (a) (h) (d)	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		10/12/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ____ B. WING ____	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow proper infection control procedures by:	F 880	" What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 880

Continued From page 21

a.) not donning the appropriate personal protective equipment (PPE) for 1 of 16 residents (Resident #148, a non-sampled resident) on Transmission-Based Precautions; and, b.) not performing hand hygiene during the medication observation pass. This deficient practice was identified for 1 of 7 nurses observed during the medication observation pass on 1 of 4 units (unit [redacted]

This deficient practice was identified during both the Standard Recertification and Covid Focused Infection Control Surveys as evidenced by the following:

1. On 10/06/20 at 11:05 AM, the surveyor observed a staff member enter a resident's room after retrieving gloves from a cart of personal protective equipment (PPE) across the hall from the resident's room. There was a sign on the wall outside of the resident's room that read, "contact precautions." Additionally, the sign read, "Visitors report to the nurses station before entering room." It also read, "Wear gown when entering patient's room if you anticipate contact with patient or environment; Remove gown before leaving room." While outside the resident's room, the surveyor overheard the staff member say, "I'm just going to lift you up a little." After a few minutes, the surveyor applied the appropriate PPE and entered the room. The staff person was observed to wash her hands in the resident's sink. The surveyor asked who she was and what she was doing for the resident. The staff member stated her name and that she was a Speech Therapist (ST). The (ST) said, "The resident is [redacted]. I did oral hygiene; I took a swab with a dab of water, wiped the [redacted], made sure

F 880

practice;

1: Resident #148- Employee was provided an in-service and given a competency test to ensure understanding of facility/state policies regarding proper donning/doffing of PPE. The in-service and competency included education on contact precautions. Employee was able to provide verbal understanding as well as return demonstration.

2. LPN on unit [redacted] was issued an in-service and completed a competency on proper hand hygiene. Both actions allowed the LPN to verbalize understanding and provide return demonstration.

" How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents have the potential of being affected by employees not adhering to proper infection control practices. A total of ten med passes were observed by the DON/designee on three shifts which included hand hygiene. In addition, ten staff employees were observed donning/doffing PPE before entering a contact precaution room by the Administrator/designee on all shifts.

" What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 [redacted] were there and took a look. I started the resident on [redacted]." The surveyor asked the ST if she noticed the sign outside the door that said, "Contact Precautions." The ST replied, "no, I didn't notice. She then looked at the sign and said, oh, that's only that 14-day thing, oh no, she's been here longer than that. I don't know. I should have asked the nurse. I didn't notice the sign." On 10/6/20 at 11:15 AM, the surveyor asked the Unit Clerk (UC) why the resident was on contact precautions. The UC stated, "[The resident] is on contact precautions because [the resident] has a [redacted] on their skin. [redacted] is coming [redacted]." The surveyor then spoke with the Licensed Practical Nurse (LPN) assigned to the resident and asked, when someone was on contact precautions, what would you wear when you entered the room and were going to touch the resident? The LPN replied, "gown, gloves, face shield in case of a splash." The surveyor then asked why they put the sign outside of the resident's room. The LPN stated, "So people know before they go in the room that they have to ask the nurse and wear PPE." On 10/6/20, at 11:30 AM, the surveyor reviewed the involved unsampled resident's medical record (resident #148). The record revealed that the resident was admitted to the facility with diagnoses that included [redacted]. There was a physician's order dated [redacted] which read, "Single room Contact Isolation for [redacted]. All services to be rendered in the patient's room."	F 880	All employees were provided an in-service on the facility infection prevention and infection control policy, including PPE donning/doffing and hand hygiene. " How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The date for correction and the title of the person responsible for correction of deficiency The corrective action will be monitored by the DON/designee. An audit of one employee during med pass including hand hygiene weekly for twelve weeks, then monthly for three months to ensure that proper infection control protocols are in place. Administrator/designee will audit one employee donning/doffing PPE prior to entry into an area designated for contact precautions weekly for twelve weeks, then monthly for three months. This will ensure that infection control protocol is in place and deficient practice will not recur. Results of the audit will be reviewed by the Administrator quarterly at the QA meeting for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

On 10/06/20 at 2:06 PM, the survey team spoke with the Director of Nursing, the Assistant Director of Nursing, the Regional Nurse, and the Administrator and made them aware of the concern that the ST entered the resident's room, and made contact with the resident without the proper PPE. They nodded in agreement that it was a concern but offered no further comments.

On 10/8/20 at 11 AM, the surveyor reviewed the facility's policy and procedure titled "Categories of Transmission Based Precautions." The policy statement read, "Standard precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others." Under "Contact Precautions," it read; "In addition to standard precautions implement contact precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Under "Examples of infections requiring Contact Precautions include, but are not limited to," number 9 read "Scabies." Letter d. under "Gown" read "(1) In addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, non-sterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. (2) After removing gown, do not allow clothing to contact potentially contaminated environmental surfaces."

2. On 10/01/20 at 9:15 AM, during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE** **MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24	F 880		

Medication Observation Pass, the surveyor observed the [redacted] Licensed Practical Nurse (LPN) remove her gloves after administering medications to a resident. She then proceeded to prepare and administer medications to a resident without performing hand hygiene.

The surveyor interviewed the LPN regarding the proper procedure of hand hygiene after removing gloves. The LPN stated that she should have performed hand hygiene after removing her gloves, and that she was aware of the facility's policy regarding performing hand hygiene after removal of the gloves.

On 10/5/20 at 1:20 PM, the surveyor discussed the above concerns with the Administrator and Director of Nursing. No additional information was provided.

A review of the facility's policy titled Handwashing/Hand Hygiene under Policy Interpretation and Implementation #9. "The use of gloves does not replace hand washing/hand hygiene. Integration of glove use, along with routine hand hygiene, is recognized as the best practice for preventing healthcare-associated infections.

The facility policy for Applying and Removing Gloves under #3, read "When removing gloves, pinch the glove at the wrist and peel away from the hand, turning the glove inside out. #4. "Hold the removed glove in the gloved hand and remove the other glove by rolling it down the hand and folding it into the first glove." #5. "Perform hand hygiene."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE** **MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 NJAC 8:39-19.1,4 (a)	F 880		