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 ______	C 07/29/2021

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

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F 000	INITIAL COMMENTS C #: NJ00141380 CENSUS: 250 SAMPLE SIZE: 3 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		8/24/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | | 08/10/2021

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.

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F 842	Continued From page 1 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842		

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F 842	Continued From page 2 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C #: NJ00141380 Based on interviews and medical record (MR) review, as well as review of pertinent facility documents on 7/29/21 and 8/2/21, it was determined that the facility failed to ensure that the Resident's MR was complete and accurate and in accordance with acceptable standards and practices for 1 of 3 residents (Res #1) reviewed for medical record. This deficient practice is evidenced by the following: According to the "ADMISSION RECORD" Res #1 was admitted to the facility on [redacted] and discharged from the facility on [redacted] with diagnoses that included but were not limited to: [redacted]. The Minimum Data Set (MDS), an assessment tool dated [redacted] showed that Res #1 was cognitively intact and required extensive assistance from staff with Activities of Daily Living (ADL). Res #1's Care Plan (CP) initiated and revised on [redacted] showed that Res #1 had decreased function in all areas of ADL due to recent hospitalization. Interventions included: assist with bed mobility, hygiene and grooming. The CP further showed that on [redacted], the Resident had an [redacted] to the [redacted] area. The form "Documentation Survey Report V (version) 2 (DSRV2)" dated [redacted] and [redacted] for completion of ADL under "Intervention/Task" did not indicate that the bed mobility, skin	F 842	F842 D What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #1 was found to have been missing documentation regarding bed mobility, skin observation, personal hygiene and transfer. Resident is now deceased. Audit of all resident's chart and POC completed and in compliance. 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 to be affected. An audit will be performed on 100 percent of residents to ensure no other residents were affected. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur; The DON/ designee will audit resident records once a week for 3 months In-service education was provided to all staff regarding medical records and	

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F 842	Continued From page 3	F 842		

observation, personal hygiene and transfer were provided to the Resident on the following dates and time:

Bed Mobility and Skin observation:
On [redacted], [redacted] to [redacted], and [redacted] during the 11:00 pm to 7:00 am shift.
On [redacted], during the 3:00 pm to 11:00 pm shift.
On [redacted], during the 7:00 am to 3:00 pm shift.

Personal Hygiene, and Transferring
On [redacted], during the 3:00 pm to 11:00 pm shift.
On [redacted], during the 7:00 am to 3:00 pm shift.

Res #1's progress notes did not indicate that the aforementioned tasks were provided to the Resident on the aforementioned dates/time.

The surveyor conducted an interview with the Director of Nursing (DON) and Certified Nursing Assistant (CNA) on 7/29/21 from 11:03 am to 1:38 pm. The DON and CNA could not explain why the aforementioned task was not documented on the aforementioned dates/time to indicate that the task was provided to the Resident and to reflect the completeness of the Resident's MR.

The facility's policy titled "Charting and Documentation", reviewed and revised on 1/2021, showed "Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary

documentation.
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 DON or designee will audit 3 resident charts weekly for 6 weeks, then monthly for three months, to ensure that all medical and ADL are documented. Results of the audit will be reviewed by the administrator monthly at the QAPI meeting for 3 months.

The DON or designee will audit all POC 3 weekly for 6 weeks, then monthly for three months, to ensure that all medical and ADL are documented. Results of the audit will be reviewed by the administrator monthly at the QAPI meeting for 3 and quarterly at the QA meeting x2

Date of completion August 24th 2021

Shabsi Ganzweig, LNHA
Administrator

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F 842	Continued From page 4 team regarding the resident's condition and response to care...2. The following information is to be documented in the resident medical record:...c. Treatment or services performed...5. Documentation of procedure and treatments will include care-specific details, including...e. Whether the resident refused the procedure/treatment...g. The signature and title of the individual documenting." NJAC: 8:39-35.2 (d)(6)	F 842		