STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING **01** B. WING _____	**10/25/2023**

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
K 000	INITIAL COMMENTS A Life Safety Code Renovation Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/25/2023, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The building is a three-story building that was built in 90's, It is composed of Type II protected. The facility is divided into 45 smoke zones. The two facility generators do 100 % of the building. 1) Cummins 750 KW 2) Cat 600 KW	K 000		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility	K 372	1. All residents have the potential to be	10/26/23

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

Electronically Signed | 10/30/2023

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 **01** B. WING _____	**10/25/2023**

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
K 372	Continued From page 1 provided documentation on 10/25/2023, it was determined that the facility failed to maintain the integrity of [redacted] partitions for two (2) of seven (7) smoke barrier walls inspected as evidenced by the following: During the survey entrance on 10/25/2023 at 9:22 AM, a request was made to the Administrator and Corporate Project Manager (CPM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments that are going to be inspected for the Renovation project. A review of the facility provided lay-out identified this inspection is the [redacted] floor corridors and the [redacted] floor center corridor and Atrium. There are nine (9) smoke barrier walls in the areas to be inspected. Starting on 10/25/2023 at approximately 10:00 AM, in the presence of the facility's Corporate Maintenance Director (CMD) and Facility Maintenance Director (FMD) an inspection above the corridor ceiling tiles of 7 smoke barrier walls was performed. The surveyor observed the following smoke barrier walls failed to maintain the 1/2 hour fire rated construction as required by code in the following locations: 1. At approximately 11:54 AM, on the [redacted] floor [redacted] corridor Leading to the Service corridor, the surveyor observed above the ceiling tiles of the corridor double smoke doors, one (1) approximately 1" by 1" penetration with 2 gray wires running through the smoke barrier wall. This penetration was observed on both sides through the smoke barrier wall, indicating that it	K 372	affected by this deficient practice. 2. The two penetrations were repaired on 10/26/23. The facility maintenance director and his staff were educated on the requirement to maintain the integrity of smoke barrier partitions and maintain the ½ hour fire rated construction as required by code. 3. The DOM/Designee will audit the smoke barrier wall doors monthly x3 months for any penetrations and submit findings to the facility administrator. Any deficient system observed during the audits will be corrected immediately. 4. Audit findings will be submitted to the Quarterly QA Committee meeting x3 Quarters to review and determine if further interventions are needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING **01** B. WING _____	**10/25/2023**

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
K 372	Continued From page 2 was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. 2. At approximately 12:04 PM, on the [redacted] floor corridor leading to the Physical Therapy and Business Offices areas the surveyor observed above the ceiling tiles of the corridor double smoke doors, one (1) approximately 1" penetration with 1 red wire and 2 gray wires running through the smoke barrier wall. This penetration was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The CMD and FMD confirmed the above findings at the time of the observations. On 10/25/2023 during the survey exit at approximately 1:06 PM, the surveyor informed the Administrator of the above findings for fire safety hazard. NJAC 8:39- 31.2(e).	K 372		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315303	A. Building 01 - MAIN BUILDING 01 B. Wing	11/3/2023

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 10/26/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO