STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061411	A. BUILDING: _____ B. WING _____	C 09/12/2023

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) COMPLETE DATE
S 000	Initial Comments NJ Complaint #:158624, 160647, 160940, 161074, 162472, 163219, 164434, 165161, 165285, 166991 Survey Dates: 09/08/23, 09/11/2023, 09/12/23 Sample Size: 23 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ #158624, 165161 Based on interviews and review of other facility documents, it was determined that the facility failed to a.) accurately report the direct care staff -to-resident ratios and b.) maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey for 70 of 133 day shift reviewed as follows.	S 560	1. The facility cannot retroactively correct this deficient practice. 2. All residents are at risk of being affected by this deficient practice. 3. Staffing coordinator was in-serviced on 9/11/23 by administrator regarding state staffing ratio requirements and calculations. Facility hired full-time recruiter to ensure all nursing positions	9/26/23

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

Electronically Signed | 09/22/23

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S 560	Continued From page 1 This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties. One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. On 9/08/2023 at 11:24 AM, the surveyors obtained the staffing assignment sheet for unit 2 A from a staff member who identified herself as a Unit Clerk, UC #2. The staff members were identified to the surveyors as listed on the assignment sheets by the Registered Nurse/Unit Manager (RN/UM #1). On 09/08/2023 at 11:24 AM, the surveyors obtained the staffing assignment sheet for unit 2	S 560	and requirements are filled. Additional staffing agency brought on. Transportation for staff is provided by facility. Weekend bonuses were increased. Job board postings sponsorships increased. 4. Administrator or designee will audit daily staffing daily x4 weeks, weekly x8 weeks, and bring results to quarterly QAPI meeting.	

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S 560	Continued From page 2 B from a staff member who identified herself as a Unit Clerk, UC #3. The staff members were identified to the surveyors as listed on the assignment sheets by the RN/UM #2. On 09/08/2023 at 11:30 AM, the surveyor obtained the staffing assignment sheet for unit 1 A from a staff member who identified herself as a Unit Clerk, UC #1. The staff members were identified to the surveyors as listed on the assignment sheets by the Licensed Practical Nurse/Unit Manager (LPN/UM #1). On 09/08/23 at 11:30 AM, the surveyor obtained the staffing assignment sheet for unit 1 B from the LPN #1. The staff members were identified to the surveyors as listed on the assignment sheets by LPN #1. On 09/08/2023 at 11:40 AM, the surveyor obtained the staffing assignment sheet for unit 1 D from LPN/UM#2. The staff members were identified to the surveyor as listed on the assignment sheets by LPN/UM#2 On 9/08/2023 at 12:25 PM, the surveyors obtained the staffing assignment sheet for unit 2 D from RN/UM #3. The staff members were identified to the surveyors as listed on the assignment sheets by RN/UM #3. The RN/UM #3 identified CNA#2 and CNA#3 but stated that they were both doing a 1:1 (1 CNA to 1 Resident) observation today and were not listed on the assignment sheet. Review of the "New Jersey Department of Health (NJDOH) Nursing Home Resident Care Staffing Report" dated 09/08/23-Day Shift revealed the Current Resident Census:249; # staff: 31 CNAs for the 7:00 AM-3:00 PM shift, staff to resident	S 560		

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S 560	Continued From page 3 ratio: 1 CNA: 8 residents. The Director of Nursing (DON) provided the survey team with the facility's "actual working schedules" for 9/08/2023 at 11:52 AM. After review of the "actual working schedules" under "Nursing" there were a total of 31staff members listed as CNAs. The survey team identfied the following discrepencies with 5 of the staff members listed as CNAs on the "actual working schedules" versus the assignment sheets from the units listed as follows: Unit 1 A staffing sheet listed UC #1 as a CNA. (Review of the staffing assignment sheets for Unit 1 A did not list UC #1 as a CNA and as having an assignment) Unit 2 A staffing sheet listed UC #2 as a CNA. (Review of the staffing assignment sheets for Unit 2 A did not list UC #2 as a CNA and as having an assignment) Unit 2 B staffing sheet listed UC #3 as a CNA. (Review of the staffing assignment sheets for Unit 2 B did not list UC #3 as CNA and as having an assignment) Unit 2 D staffing sheet listed CNA #2 and CNA #3 as assigned to 1:1's (one CNA to one resident) (review of the staffing assignment sheets did not list CNA# 3 or CNA #4 as having an assignment) On 09/08/2023 at 1:45 PM, during an interview with the surveyors, RN/UM #2 stated that UC #3 was the "unit secretary" and not working as a CNA. UC #3 was unavailable for an interview at that time. On 09/08/2023 at 1:51 PM, during an interview	S 560		

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S 560	Continued From page 4	S 560		

with the surveyors, UC#2 stated that she was formerly a CNA and was still licensed, but she was no longer working as a CNA. She stated she was currently working as a Unit Clerk. She stated she did not have a CNA assignment because her position was a Unit Clerk.

On 09/08/2023 at 2:05 PM, during an interview with the surveyors, UC#3 stated that she was a CNA at her previous employment. She stated she was hired by the facility as a Unit Clerk about 1 year ago and works only as a Unit Clerk at the facility.

On 09/08/2023 at 2:35 PM, in the presence of the survey team and the Licensed Nursing Home Administrator (LNHA), the staffing coordinator stated that she was aware of the current CNA staffing ratios and that the facility has been meeting the ratios. She stated that she reviews the nursing schedule and enters the discipline listed on the schedule into a computer system that calculates the numbers to report to the NJDOH. The surveyor asked about CNA #3, CNA #4, UC#2 and UC#3 being included in the CNA ratios that were being reported, the LNHA stated "yes they count them because they are on the floor." The LNHA stated that the Unit Clerks were counted because they "are assisting all over the floor."

Review of facility provided employee files revealed that UC#1, UC #2 and UC #3 had current CNA licenses. Further review of employee files revealed that UC #2 job description for Unit Clerk was signed on 1/14/2018 and UC #3 was hired as a Unit Clerk and signed the Unit Clerk job description on 6/7/2022.

On 9/12/2023 at 11:05 AM, in the presence of the

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S 560	Continued From page 5 survey team, the LNHA stated that the date that UC #2 and UC #3 signed their job description was the date they started as a Unit Clerk with the facility. 2. For the 2 weeks of Complaint staffing from 09/11/2022 to 09/24/2022, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -09/11/22 had 23 CNAs for 245 residents on the day shift, required at least 31 CNAs. -09/18/22 had 29 CNAs for 245 residents on the day shift, required at least 31 CNAs. -09/24/22 had 26 CNAs for 245 residents on the day shift, required at least 31 CNAs. 3. For the 2 weeks of Complaint staffing from 12/25/2022 to 01/07/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -12/25/22 had 16 CNAs for 233 residents on the day shift, required at least 29 CNAs. -12/26/22 had 23 CNAs for 233 residents on the day shift, required at least 29 CNAs. -12/31/22 had 22 CNAs for 233 residents on the day shift, required at least 29 CNAs. -01/01/23 had 25 CNAs for 232 residents on the day shift, required at least 29 CNAs. -01/02/23 had 19 CNAs for 232 residents on the day shift, required at least 29 CNAs. -01/04/23 had 28 CNAs for 232 residents on the day shift, required at least 29 CNAs. 4. For the 3 weeks of Complaint staffing from 01/15/2023 to 02/04/2023, the facility was deficient in CNA staffing on 10 of 21 day shifts as follows:	S 560		

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S 560	Continued From page 6 -01/15/23 had 20 CNAs for 233 residents on the day shift, required at least 29 CNAs. -01/20/23 had 26 CNAs for 233 residents on the day shift, required at least 29 CNAs. -01/21/23 had 26 CNAs for 233 residents on the day shift, required at least 29 CNAs. -01/22/23 had 25 CNAs for 233 residents on the day shift, required at least 29 CNAs. -01/23/23 had 25 CNAs for 233 residents on the day shift, required at least 29 CNAs. -01/28/23 had 24 CNAs for 235 residents on the day shift, required at least 29 CNAs. -01/29/23 had 20 CNAs for 235 residents on the day shift, required at least 29 CNAs. -02/01/23 had 28 CNAs for 235 residents on the day shift, required at least 29 CNAs. -02/03/23 had 27 CNAs for 235 residents on the day shift, required at least 29 CNAs. -02/04/23 had 24 CNAs for 235 residents on the day shift, required at least 29 CNAs. 5. For the 3 weeks of Complaint staffing from 02/19/2023 to 03/11/2023, the facility was deficient in CNA staffing for residents on 14 of 21 day shifts as follows: -02/19/23 had 19 CNAs for 245 residents on the day shift, required at least 31 CNAs. -02/20/23 had 25 CNAs for 245 residents on the day shift, required at least 31 CNAs. -02/22/23 had 30 CNAs for 245 residents on the day shift, required at least 31 CNAs. -02/24/23 had 28 CNAs for 245 residents on the day shift, required at least 31 CNAs. -02/25/23 had 24 CNAs for 245 residents on the day shift, required at least 31 CNAs. -02/26/23 had 24 CNAs for 247 residents on the day shift, required at least 31 CNAs. -02/27/23 had 21 CNAs for 246 residents on the day shift, required at least 31 CNAs.	S 560		

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S 560	Continued From page 7 -02/28/23 had 29 CNAs for 246 residents on the day shift, required at least 31 CNAs. -03/03/23 had 23 CNAs for 246 residents on the day shift, required at least 31 CNAs. -03/04/23 had 21 CNAs for 243 residents on the day shift, required at least 30 CNAs. -03/05/23 had 22 CNAs for 243 residents on the day shift, required at least 30 CNAs. -03/06/23 had 28 CNAs for 243 residents on the day shift, required at least 30 CNAs. -03/10/23 had 29 CNAs for 241 residents on the day shift, required at least 30 CNAs. -03/11/23 had 24 CNAs for 241 residents on the day shift, required at least 30 CNAs. 6. For the 7 weeks of Complaint staffing from 04/30/2023 to 06/17/2023, the facility was deficient in CNA staffing for residents on 29 of 49 day shifts as follows: -04/30/23 had 15 CNAs for 246 residents on the day shift, required at least 31 CNAs. -05/01/23 had 24 CNAs for 244 residents on the day shift, required at least 30 CNAs. -05/03/23 had 26 CNAs for 244 residents on the day shift, required at least 30 CNAs. -05/05/23 had 22 CNAs for 244 residents on the day shift, required at least 30 CNAs. -05/06/23 had 18 CNAs for 244 residents on the day shift, required at least 30 CNAs. -05/07/23 had 15 CNAs for 243 residents on the day shift, required at least 30 CNAs. -05/08/23 had 18 CNAs for 242 residents on the day shift, required at least 30 CNAs. -05/09/23 had 24 CNAs for 242 residents on the day shift, required at least 30 CNAs. -05/10/23 had 25 CNAs for 242 residents on the day shift, required at least 30 CNAs. -05/12/23 had 26 CNAs for 246 residents on the day shift, required at least 31 CNAs.	S 560		

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S 560	Continued From page 8 -05/13/23 had 26 CNAs for 245 residents on the day shift, required at least 31 CNAs. -05/14/23 had 18 CNAs for 245 residents on the day shift, required at least 31 CNAs. -05/15/23 had 21 CNAs for 245 residents on the day shift, required at least 31 CNAs. -05/16/23 had 27 CNAs for 245 residents on the day shift, required at least 31 CNAs. -05/17/23 had 29 CNAs for 249 residents on the day shift, required at least 31 CNAs. -05/18/23 had 29 CNAs for 247 residents on the day shift, required at least 31 CNAs. -05/19/23 had 27 CNAs for 247 residents on the day shift, required at least 31 CNAs. -05/20/23 had 19 CNAs for 245 residents on the day shift, required at least 31 CNAs. -05/21/23 had 16 CNAs for 242 residents on the day shift, required at least 30 CNAs. -05/22/23 had 25 CNAs for 242 residents on the day shift, required at least 30 CNAs. -05/24/23 had 29 CNAs for 242 residents on the day shift, required at least 30 CNAs. -05/26/23 had 25 CNAs for 243 residents on the day shift, required at least 30 CNAs. -05/27/23 had 22 CNAs for 243 residents on the day shift, required at least 30 CNAs. -05/28/23 had 14 CNAs for 243 residents on the day shift, required at least 30 CNAs. -05/31/23 had 29 CNAs for 243 residents on the day shift, required at least 30 CNAs. -06/01/23 had 28 CNAs for 243 residents on the day shift, required at least 30 CNAs. -06/02/23 had 28 CNAs for 243 residents on the day shift, required at least 30 CNAs. -06/11/23 had 18 CNAs for 237 residents on the day shift, required at least 30 CNAs. -06/12/23 had 26 CNAs for 236 residents on the day shift, required at least 29 CNAs. 7. For the 2 weeks of Complaint staffing from	S 560		

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S 560	Continued From page 9 08/20/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -08/20/23 had 17 CNAs for 241 residents on the day shift, required at least 30 CNAs. -08/25/23 had 28 CNAs for 239 residents on the day shift, required at least 30 CNAs. -08/26/23 had 28 CNAs for 239 residents on the day shift, required at least 30 CNAs. -08/27/23 had 20 CNAs for 239 residents on the day shift, required at least 30 CNAs. -08/28/23 had 27 CNAs for 239 residents on the day shift, required at least 30 CNAs. -08/29/23 had 29 CNAs for 241 residents on the day shift, required at least 30 CNAs. -08/30/23 had 27 CNAs for 241 residents on the day shift, required at least 30 CNAs. -09/02/23 had 28 CNAs for 246 residents on the day shift, required at least 31 CNAs. On 09/08/23 at 11:45, during an interview with the surveyors on unit 2 A, CNA#4 stated that she had 12 residents in her assignment. She stated that 12 residents was a usual assignment for her and "sometimes she cant get everything done, everyday is different." On 9/08/23 at 12:51 PM, during an interview with the surveyors on unit 2 D, CNA #5 stated he had 11 residents in his assignment, and he can usually get everything done. A review of the facility's policy, "Staffing" with a reviewed/revised dated 12/2022, revealed under Policy Interpretation and Implementation: 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. 4. Direct care staffing information per day is	S 560		

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S 560	Continued From page 10 submitted to the CMS payroll-based journal system on the schedule specified by CMS.	S 560		

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	315303	A. BUILDING _____ B. WING _____	C 09/12/2023

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F 000	INITIAL COMMENTS Complaint #: 158624, 160647, 160940, 161074, 162472, 163219, 164434, 165161, 165285, 166991 Survey Dates: 09/08/23, 09/11/2023, 09/12/23 Census: 249 Sample Size: 23 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 VISIT.	F 000		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the	F 573		9/26/23

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

Electronically Signed | 09/22/2023

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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 573	Continued From page 1 facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by: NJ#00163219, NJ# 00164434 Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to provide a discharged resident a requested copy of their medical records. This deficient practice was identified for 1 of 2 residents (Resident #1) reviewed for medical record requests. This deficient practice was evidenced by the following: According to the Admission record, Resident #1	F 573	1. Resident # 1□s responsible party was contacted on 9/12/23, and sent a follow-up email on the 14th, to pick up the medical records. 2. All residents are at risk to be affected by this deficient practice. All medical record requests are being reviewed to ensure timely delivery. 3. Medical Records clerk was in-serviced on 9/22/23 by the administrator regarding the requirements to provide access to records within 24 hours and copies of records within 48 hours.	

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 09/12/2023

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F 573	Continued From page 2 was admitted to the facility in [redacted] with diagnoses which included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], indicated Resident #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted]. Review of the facility provided "Release Authorization Information from Medical Records" form revealed that Resident #1 and their [redacted] signed the request form on [redacted] On 9/11/23 at 12:34 PM, the Licensed Nursing Home Administrator (LNHA) stated that once the medical record request was received the medical record is sent to the Medical Director (MD) for review. He further stated that after the MD reviewed the medical record, a copy was sent to the resident/resident representative. The LNHA stated, there was "no record of completing this request" for Resident #1 and it was an "oversight" by the facility. He then stated, "the family never called to follow up" on the request. Review of the facility's policy "Release of Information" with a reviewed/revised date of 12/2022, revealed under "Policy Interpretation and Implementation": 1. Each resident will receive confidential treatment of his or her personal and medical records and may approve or refuse their release to any individual outside the facility. 3. All information contained in the resident's medical record is confidential and may only be released by the written consent of the resident or his/her	F 573	4. Administrator or designee will audit one record request a month for three months to ensure fulfilled in a timely manner and bring results to quarterly QAPI meeting.	

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F 573	Continued From page 3 legal representative. 8. The resident ...Such requests will be honored only upon the receipt of written, signed, and dated request from the resident or representative. 9. A resident may have access to his or her records within 48 hours (excluding weekends or holidays) of the resident's written or oral request. NJAC 8:39-35.2(h)	F 573		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		9/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 4 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint # NJ00161074 Based on observations, interviews, and review of pertinent facility documentation, it was identified that the facility failed to provide a sanitary and homelike environment on 1 of 6 units toured [redacted] for 3 of 13 resident rooms (Resident #11, #13 and #14). This deficient practice was evidenced by the following: On 09/08/23 at 12:38 PM, during the initial tour of unit [redacted] the surveyors observed a brown, cloth [redacted] in Resident #13's room. The recliner had multiple areas of [redacted]. There was an [redacted] on the seat of the chair. Resident #13 was not in the room at the time of the observation. On 09/08/23 at 12:40 PM, in the presence of the surveyors, the Registered Nurse/Unit Manager (RN/UM) stated that Resident #13's [redacted] chair	F 584	1. Resident # 13's [redacted] was removed and replaced on 9/11/23. Resident # 11's [redacted] was replaced on 9/11/23. Resident # 14's chair was cleaned on 9/11/23. 2. All residents are at risk to be affected by this deficient practice. 3. Administrator/Designee in-serviced all staff on requirements to provide a sanitary and homelike environment. 4. Designee will audit 2 rooms a week for a month, then 1 room a week for 2 months to ensure they are sanitary and homelike, then report those findings to the quarterly QAPI meeting. All resident rooms audited to ensure cleanliness.	

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F 584	Continued From page 5	F 584		

"should not be that way." She further stated that the chair should be "kept clean for infection control and dignity purposes." When the surveyors asked if she would sit in the recliner chair, the RN/UM stated "no" she would not. The RN/UM stated she was going to call housekeeping to have the recliner chair removed and cleaned.

On 09/08/23 at 12:49 PM, the surveyors, in the presence of the Regional Director of Clinical Compliance (RDCC), stopped the housekeeper from removing the recliner chair from the unit so that the RDCC could see it. The RDCC stated that "no doubt the chair needs to be cleaned." She stated that the reason was to keep the "environment clean, sanitary, and a homelike environment." When the surveyors asked if she would want her loved one sitting in that recliner chair, the RDCC stated, "no" she would not. She further stated that she would expect the staff to report the recliner chair to housekeeping so that it could be "properly" cleaned.

On 09/08/23 at 12:50 PM, during an interview with the surveyors, Certified Nursing Assistant (CNA) #1 stated that if a resident's chair was "dirty", he would try to clean it and if he was unable to get it clean, he would call housekeeping.

On 09/08/23 at 12:51 PM, during an interview with the surveyors, CNA #2 stated that the residents are "human beings and that their areas should be kept clean."

On 09/11/23 at 08:26 AM, in the presence of the RN/UM and CNA #3 on unit [redacted], the surveyors observed a [redacted] on Resident #11's

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F 584	Continued From page 6 [redacted]. The RN/UM stated that "it" (the [redacted]) should not be there and that she would call housekeeping. On 09/11/23 at 08:26 AM, in the presence of the RN/UM and CNA #3 on unit [redacted] the surveyors observed a [redacted] on the seat and on the side of the seat of Resident #14's vinyl-like covered chair. The RN/UM stated "it" ([redacted]) should not be there and asked CNA#3 to clean the chair. On 09/12/23 at 11:05 AM, in the presence of the RDCC, the surveyor made the Director of Nursing (DON) aware of the above findings. The DON stated that she would expect the staff to call housekeeping or maintenance to clean or replace anything that was soiled and that they (the staff) should address it (the soiled item) at that time. On 9/12/23 at 11:50 AM, the surveyor, in the presence of the survey team, made the Licensed Nursing Home Administrator (LNHA) aware of the above findings. He stated that the Assistant LNHA (ALNHA) made environmental rounds daily on the units. He stated that the ALNHA would enter things that needed maintenance in the maintenance reporting system or would alert the Housekeeping Director as needed. The LNHA stated that the unit managers should make rounds daily in the rooms and alert maintenance or housekeeping as soon a soiled item was discovered. NJAC 8:39-31.4(a)(c)(f)	F 584		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061411		10/2/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/26/2023	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
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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	
9/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315303 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 10/2/2023 Y3

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 F0573 Reg. # 483.10(g)(2)(i)(ii)(3) LSC	Correction Completed 09/26/2023	ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 09/26/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
9/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO