STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315157	A. BUILDING _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISTOWN POST ACUTE REHAB AND NURSING CENTER	77 MADISON AVENUE MORRISTOWN, NJ 07960

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F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 01/02/24 - 01/05/24 Survey Census: 199 Sample Size: 42 Supplemental Residents: 0 No deficiencies were issued related to Intakes: NJ00167910 NJ00169011 NJ00167913 NJ00169217 NJ00169624 NJ00169032 NJ00169033 NJ00169038 NJ00168486 NJ00169888	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		1/23/24

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

Electronically Signed | 01/31/2024

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F 644	Continued From page 1 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify the need for a new "Preadmission Screening and Resident Review (PASARR-a screening which looks for indicators that a person may have intellectual disability, related disability, or serious mental illness") when a resident had a new diagnosis of [redacted] for one (Resident (R) 23) of three sampled residents in a total sample of 42. This failure placed the residents at risk of not receiving necessary services. Findings included. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R23 was admitted to the facility on [redacted] with diagnoses that included [redacted]. The resident did not have diagnosis of [redacted] Review of the "Medical Diagnosis" list located in	F 644	F644 1. New PASSAR for resident #23 was immediately completed. 2. All residents with diagnosis of mental illness are at risk from this deficient practice. 3. Social workers were in-serviced by regional socialworker on 1/23/24 on the requirement to identify the need for a new PASSAR when a resident has a new diagnosis of mental illness. 4. Regional nurse, or designee, will audit 3 charts a month, for 3 months to ensure that a new PASSAR was implemented for any new diagnosis of mental illness, and results brought to quarterly QAPI.	

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F 644	Continued From page 2	F 644		

the "Medical Diagnosis" tab of the EMR revealed the following NJ Exec. Order 26:4.b.1 diagnoses were added after admission to the facility: NJ Exec. Order 26:4.b.1, dated NJ Exec. Order 26:4.b.1; and NJ Exec. Order 26:4.b.1 dated, NJ Exec. Order 26:4.b.1

Review of the "Pre-Admission Screening and Resident Review (PASARR) Level I Screen" located in the "Miscellaneous" tab of the EMR, dated NJ Exec. Order 26:4.b.1 revealed R23 had NJ Exec. Order 26:4.b.1 diagnosis which was listed as NJ Exec. Order 26:4.b.1 The PASARR did not list the diagnosis of NJ Exec. Order 26 diagnosed on NJ Exec. Order 26:4.b.1 The level 1 screening was NJ Exec. Order 26:4.b.1)." The "PASARR" had not been updated when new diagnoses of NJ Exec. Order 26:4.b.1 were identified after NJ Exec. Order 26:4.b.

Review of the quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of NJ Exec. Order 26:4.b revealed R23 had a "Brief Interview of Mental Illness (BIMS)" score of NJ Exe out of 15 which indicated he was NJ Exec. Order 26:4.b.1 during the observation period.

During an interview on 01/03/24 at 2:50 PM, the Social Services Director (SSD) was asked if a new Level 1 "PASARR" had been submitted for the new diagnosis of NJ Exec. Order 26:4.b.1, as required. The SSD stated, "No, not that I am aware of. I have only been in this position since NJ Exec. Order 26:4.b.1)."

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F 644	Continued From page 3 NJAC 8:39-5.1(a)	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section-	F 645		1/23/24

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F 645	Continued From page 4 (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the "PASARR (Pre-Admission Screening and Resident Review-a screening process for residents who have indicators of intellectual disability, related disability, or serious mental illness)" was followed for one (Resident	F 645	F645 1. PASSAR for resident #43 was immediately corrected. 2. All residents with diagnosis of mental illness are at risk from this deficient	

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F 645	Continued From page 5 (R) 43) of three sampled residents in a total sample of 42. The facility failed to ensure a "PASARR Level 1" was corrected to include serious mental illness to determine if a Level II (a more in-depth screening) was required. This failure placed the resident at risk of not receiving the NJ Exec. Order 26:4.b.1 needed and placed him at risk for a diminished quality of life. Findings included. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R43 was admitted to the facility on [redacted] with diagnoses that included [redacted]. The resident did not have a diagnosis of NJ Exec. Order 26:4.b.1 . Review of the Level I "PASARR" located in the "Miscellaneous" tab of the EMR, dated [redacted] showed no diagnoses of serious NJ Exec. Order 26:4.b.1 had been documented on the Level I form therefore, no Level II screening (a more in-depth) screening was not performed. Review of the quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of [redacted] revealed R43 had a "Brief Interview of Mental Status (BIMS)" score of [redacted] out of 15 which indicated he [redacted] during the observation period.	F 645	practice. 3. Social workers were in-serviced by regional social worker on 1/23/24 on the requirement to identify the need for a PASSAR to be corrected to include serious mental illness. 4. Regional nurse, or designee, will audit 3 charts a month, for 3 months to ensure that all PASSAR's are corrected to include any new diagnosis of mental illness, and results brought to quarterly QAPI.	

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F 645	Continued From page 6 During an interview on 01/04/23 at 8:30 AM, the Social Services Director (SSD) was asked about the missing diagnoses on R43's [NJ Exec. Order 26:4.b] "PASARR" Level 1. She stated, "I wasn't here then, but I am supposed to ensure that they are correct. The "MDS" coordinator also checks, it must have been missed." NJAC 8:39-5.1(a)	F 645		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of facility policies, the facility failed to ensure one resident (Resident (R) 118)'s out of four residents' had appropriate [NJ Exec. Order 26:4.b] to prevent potential accident hazards. Findings include: Review of an undated policy provided by the facility titled, "Fall Risk Assessment" indicated ". . .The nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls and	F 689	F689 1. Resident #118 immediately had appropriate Ex.Order 26.4(b)(1) to prevent potential accident hazards put in place. 2. All residents are at risk to be affected from this deficient practice. 3. All staff were inserviced on 1/23/24 by regional educator on appropriate fall prevention interventions to prevent potential accident hazards. 4. Administrator or designee will audit 6 residents a month, for 3 months that appropriate fall prevention interventions to	1/23/24

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F 689	Continued From page 7 establish a resident-centered falls prevention plan based on relevant assessment information. . ." Review of R118's electronic medical record (EMR) titled, "Admission Record," located under the "Profile" tab, indicated the resident was admitted to the facility on [redacted] with a diagnosis of [redacted]. Review of R118's EMR titled quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located under the MDS tab indicated the staff was [redacted] the residents "Brief Interview for Mental Status (BIMS)" score and revealed the resident had [redacted]. The assessment indicated the resident [redacted] Review of R118's EMR titled nursing "Progress Notes" located under the "Prog [Progress] Notes" dated [redacted] indicated the resident slipped off the bed while one staff member was performing personal care. The resident sustained [redacted] Review of R118's EMR titled "Morse Fall Scale," located under the "Evaluations" tab dated [redacted] indicated the resident was [redacted] and scored [redacted] Review of R118's EMR titled "Care Plan" located under the "Care Plan" dated [redacted] indicated the resident was to have [redacted] present during [redacted]. Review of R118's EMR titled nursing "Progress Notes" located under "Prog Notes" dated	F 689	prevent potential accident hazards are put in place, and findings brought to quarterly QAPI meeting.	

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F 689	Continued From page 8	F 689		

NJ Exec. Order 26:4.b indicated the resident was found on the side of his bed and sustained NJ Exec. Order 26:4.b.1. The resident NJ Exec. Order 26:4.b.1. The progress notes indicated the resident's bed was in a low position.

Review of the R118's EMR titled "Care Plan" located under the "Care Plan" tab dated NJ Exec. Order 26:4.b.1 indicated the resident had a referral made to NJ Exec. Order 26:4.b.1 for evaluation.

During an observation on 01/02/24 at 10:38 AM, R118 was in bed. The bed was in the lowest position. There was a wheelchair next to the left side of his bed when facing toward the bed. In addition, there was a chair with arms on the same side but up against the end of the bed. On the right side, facing the resident there was a chair up against the end of the bed. An attempt to interview the resident was made but it was not successful. The placement of the furniture did not

During an observation on 01/03/24 at 10:00 AM, R118 was in bed and there were chairs touching each end of the bed on the left and right side when facing the resident.

During an interview on 01/03/24 at 10:33 AM, Certified Nursing Assistant (CNA) 2 stated the chairs may have been placed up against R188's bed by a family member.

During an observation on 01/04/24 at 5:42 AM, R118 was in bed. On the left side facing there were two chairs up close to the end of his bed. On the right side, facing the resident was one chair up close to the end of the bed.

During an interview on 01/04/24 at 5:47 AM, CNA 1 stated she placed the chairs next to the

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F 689	Continued From page 9 resident's bed since he tends to try and get himself out of bed. CNA 1 stated even after she placed the chairs around the bed, the resident still attempted to get out of bed. During an interview on 01/04/24 at 5:52 AM, Licensed Practical Nurse (LPN) 2, who was also the night supervisor, entered R118's room and stated she was not aware of staff using chairs to create a barrier around the resident's bed. During an interview on 01/04/24 at 5:56 AM, LPN3 stated she has seen the chairs placed around R118 in the past and confirmed she has done nothing about the removal of the chairs. During an interview on 01/04/24 at 8:08 AM, LPN4, who was also the day supervisor, stated she was aware the family of R118 placed the chairs around the resident while he was in bed. LPN4 stated the resident was unable to get out of the bed on his own and had poor safety awareness. During an interview on 01/05/24 at 10:02 AM, the Director of Nursing (DON) stated there was no information the facility spoke with the family regarding placing chairs around R118 while he was in bed. The DON stated the resident had NJ Exec. Order 26:4.b.1 when asked if the furniture was a potential accident hazard.	F 689		
F 693 SS=D	NJAC 8:39-27.1(a) Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes,	F 693		1/23/24

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F 693	Continued From page 10 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one (Resident (R) 15) of four sampled residents who were [redacted] had the [redacted] container labeled, dated, and timed, as required. This failure placed the resident at risk for having received expired and/or inaccurate [redacted] Findings included. Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R15 was admitted to the facility on [redacted] with diagnoses that included a [redacted].	F 693	F693 1. Resident #15 [redacted] was immediately labeled, dated, and timed, as required. 2. All residents on enteral feeding are at risk to be affected by this deficent practice. 3. All nurses were inserviced on 1/23/24 by regional educator on the requirement to have enteral feeding container labeled, dated, and timed, as required. 4. Director of nursing, or designee will audit 3 residents a month on enteral feeding for proper container labeled, dated, and timed, as required, for 3 months, with results brought to quarterly	

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F 693	Continued From page 11 Review of the quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of [redacted] revealed R15 had a staff assessed "Brief Interview of Mental Status (BIMS)" score [redacted] of 15 that indicated he was [redacted] During an initial observation on 01/02/24 at 9:31 AM, the [redacted] was observed hanging on the pole. The container label was blank and did not show the date, time, rate, or initial of the nurse who hung the [redacted] as required. During an observation of the [redacted] on 01/04/23 at 6:20 AM, the [redacted] was observed hanging on the pole. The container label was blank and did not show the date, time, rate, or initial of the nurse who hung the [redacted], as required. During an interview on 01/04/24 at 6:21 AM, Licensed Practical Nurse (LPN) 7 was asked what information the [redacted] should contain. LPN 7 stated, "It's supposed to have the date, time, rate and initials on the container." LPN7 confirmed the container did not contain this information. During an interview on 01/04/24 at 12:30 PM, LPN 5, who is also the unit manager for the floor, confirmed that the [redacted] are to be labeled each time they are hung.	F 693	QAPI meeting.	

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F 693	Continued From page 12 NJAC 8:39-27.1(a)	F 693		
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; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		1/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315157	A. BUILDING _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISTOWN POST ACUTE REHAB AND NURSING CENTER	77 MADISON 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 13 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, the facility failed to ensure infection control standards were performed during intravenous (IV) medication administration for one (Resident (R) 196) of one resident reviewed for NJ Exec. Order 26:4.b.1. The facility failed to ensure proper glove use was used during IV medication administration. This failure placed the	F 880	F880 1. Nurse immediately was educated on requirement to have proper glove use during IV medication administration. 2. All residents on IV medication are at risk from this deficicent prectice. 3. All nurses were educated on 1/23/24 by	

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F 880	Continued From page 14 resident at risk for cross contamination from infectious agents. Findings included. Review of the facility policy's titled, "Infection Control (IC) Guidelines For All Nursing Procedures," dated 02/2023, revealed, " ...It is the policy of this facility to adhere to infection control (IC) guidelines to limit or prevent the spread of infection between residents and/or staff ..." Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R196 was admitted to the facility on NJ Exec. Order 26:4.b with diagnoses that included NJ Exec. Order 26:4.b [redacted] Review of the "Order Summary" located in the "Orders" tab of the EMR revealed a "Physician Order," dated NJ Exec. Order 26:4.b for NJ Exec. Order 26:4.b.1 [redacted] During a medication pass observation on 01/04/24 at 5:37 AM, Registered Nurse (RN) 1 applied gloves to administer a by mouth medication. RN1 then removed her gloves, used hand hygiene and without applying clean gloves, proceeded to NJ Exec. Order 26:4.b.1 with her bare hands, administer NJ Exec. Order 26:4.b.1, and then connect NJ Exec. Order 26:4.b.1 line for the NJ Exec. Order 26:4.b.1 administration. During an interview on 01/04/24 at 5:48 AM, RN1 was asked why she did not use gloves during the administration of an NJ Exec. Order 26:4.b.1. RN 1 stated,	F 880	regional educator on the requriment to have proper glove use during IV medication administration. 4. Director of nursing or designee will audit 3 residents on IV medication a month, for 3 months, for proper glove use during IV medication administration and results brought to quarterly QAPI meeting.	

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F 880	Continued From page 15 "I should have used gloves for the IV and not the pill, I know to do that." During an interview on 01/04/24 at 9:22 AM, the Director of Nursing (DON) confirmed that gloves and hand hygiene are to be used during IV medication administration. NJAC 8:39-19.4(a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061417	A. BUILDING: _____ B. WING _____	C 01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISTOWN POST ACUTE REHAB AND NURSING (	77 MADISON AVENUE MORRISTOWN, NJ 07960

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency 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: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: 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 at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	S560 1. Facility immediately ensured that staffing coordinator is aware of proper staffing ratios. 2. All residents are at risk of being affected by this deficient practice. 3. Staffing coordinator was in-serviced on 1/23/24 by administrator regarding state staffing ratio requirements. 4. Administrator or designee will audit daily staffing twice a month for three months and bring results to quarterly QAPI meeting.	1/23/24

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

Electronically Signed | 01/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1	S 560		

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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and

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. For the 2 weeks of Complaint staffing from 08/27/2023 to 09/09/2023, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:

-09/03/23 had 20 CNAs for 202 residents on the day shift, required at least 25 CNAs.
-09/04/23 had 25 CNAs for 206 residents on the day shift, required at least 26 CNAs.
-09/05/23 had 24 CNAs for 206 residents on the day shift, required at least 26 CNAs.
-09/06/23 had 25 CNAs for 205 residents on the day shift, required at least 25 CNAs.

2. For the 2 weeks of Complaint staffing from 10/08/2023 to 10/21/2023, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:

-10/08/23 had 24 CNAs for 199 residents on the

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	061417	A. BUILDING: _____ B. WING _____	C 01/09/2024

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MORRISTOWN POST ACUTE REHAB AND NURSING (	77 MADISON AVENUE MORRISTOWN, NJ 07960

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S 560	Continued From page 2	S 560		

day shift, required at least 25 CNAs.
-10/09/23 had 23 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-10/16/23 had 24 CNAs for 197 residents on the day shift, required at least 25 CNAs.

3. For the 3 weeks of Complaint staffing from 10/29/2023 to 11/18/2023, the facility was deficient in CNA staffing on 2 of 21 day shifts as follows:

-10/30/23 had 24 CNAs for 201 residents on the day shift, required at least 25 CNAs.
-11/06/23 had 24 CNAs for 198 residents on the day shift, required at least 25 CNAs.

4. For the 2 weeks of Complaint staffing from 12/03/2023 to 12/16/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows:

-12/03/23 had 22 CNAs for 202 residents on the day shift, required at least 25 CNAs.
-12/07/23 had 24 CNAs for 199 residents on the day shift, required at least 25 CNAs.
-12/08/23 had 24 CNAs for 197 residents on the day shift, required at least 25 CNAs.
-12/09/23 had 23 CNAs for 196 residents on the day shift, required at least 24 CNAs.
-12/16/23 had 24 CNAs for 197 residents on the day shift, required at least 25 CNAs.

5. For the 2 weeks of staffing prior to survey from 12/17/2023 to 12/30/2023, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:

-12/17/23 had 22 CNAs for 197 residents on the day shift, required at least 25 CNAs.
-12/19/23 had 23 CNAs for 195 residents on the

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S 560	Continued From page 3 day shift, required at least 24 CNAs. -12/24/23 had 22 CNAs for 187 residents on the day shift, required at least 23 CNAs. -12/30/23 had 21 CNAs for 195 residents on the day shift, required at least 24 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315157 Y1	A. Building B. Wing Y2	2/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISTOWN POST ACUTE REHAB AND NURSING CENTER	77 MADISON 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 F0644	Correction	ID Prefix F0645	Correction	ID Prefix F0689	Correction
Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.20(k)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	01/23/2024	LSC	01/23/2024	LSC	01/23/2024
ID Prefix F0693	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.25(g)(4)(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	01/23/2024	LSC	01/23/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/9/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061417		2/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISTOWN POST ACUTE REHAB AND NURSING CENTER	77 MADISON AVENUE MORRISTOWN, NJ 07960

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 01/23/2024	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
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

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	
1/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315157	A. BUILDING **01** B. WING _____	**01/09/2024**

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MORRISTOWN POST ACUTE REHAB AND NURSING CENTER	**77 MADISON AVENUE** **MORRISTOWN, NJ 07960**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/09/2024. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/09/24 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. Morristown Post Acute Rehab and Nursing Center is a five-story building with a basement that was built in 1971. The facility is composed of Type I protected construction. The facility is divided into 10 - smoke zones. The generator does approximately 50 % of the building per the Maintenance Director. The current occupied beds are 209 of 287.	K 000		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.	K 351		2/5/24

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

Electronically Signed | 02/01/2024

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	315157	A. BUILDING **01** B. WING _____	**01/09/2024**

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K 351	Continued From page 1 In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure sprinkler heads were installed on four balconies in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) section 8.15.7.1; and that the sidewall spray sprinkler escutcheons caps were not painted in the rehabilitation area in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) section 6.2.7.2. This deficient practice had the potential to affect all 209 residents who resided at the facility. Findings include: An observation on 01/09/24 at 11:22 AM revealed that no sprinkler heads were installed on the four balconies located adjacent to each resident sitting area. An observation on 01/09/24 at 12:00 PM revealed that seven out of 10 escutcheon caps on the side wall sprinkler heads were painted in the rehabilitation area.	K 351	1. Sidewall spray sprinkler escutcheons caps were immediately replaced with those not painted in the rehabilitation area. Quote obtained for installation of sprinkler heads on four balconies. 2. All residents are at risk to be affected by this deficient practice. 3. Maitenance director was inserviced by Administrator on 1/23/24 regarding ensuring sprinkler heads were installed on four balconies and that the sidewall spray sprinkler escutcheons caps were not painted in the rehabilitation area. 4. Administrator or designee will audit 2 escutcheons caps a month to ensure they are not painted, for 3 months, and findings brought to quarterly QAPI meeting.	

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K 351	Continued From page 2 During an interview at the time of the observations, the Director of Maintenance confirmed the sprinkler heads were not installed on the balconies and that the escutcheon caps were painted. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in	K 914	1. Facility immediately ensured electrical outlet testing was conducted on the electrical system. Inspection report	1/23/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISTOWN POST ACUTE REHAB AND NURSING CENTER	**77 MADISON 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 914	Continued From page 3 accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. This deficient practice had the potential to affect all 209 residents who resided at the facility. Findings include: A review of the facility's "Fire Safety Folder for 2023," provided by the Maintenance Director, revealed the electrical outlet testing was not completed on the electrical outlets. During an interview on 01/09/24 at 1:30 PM, the Maintenance Director confirmed that the electrical outlet testing was completed on the electrical system but was not documented. NJAC 8:39-31.2(e) NFPA 99	K 914	provided. 2. All residents are at risk of being affected by this deficient practice. 3. Maintenance director was inserviced by Administrator on 1/23/24 regarding the requirement to have electrical outlet testing conducted on the electrical system annually. 4. Administrator or designee will audit log for 2 outlets tested a month, for 3 months, and results brought to quarterly QAPI meeting.	

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)
315157	A. Building 01 - MAIN BUILDING 01 B. Wing	2/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRISTOWN POST ACUTE REHAB AND NURSING CENTER	77 MADISON 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 K0351	Correction Completed 02/05/2024	ID Prefix Reg. # NFPA 101 LSC K0914	Correction Completed 01/23/2024	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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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
1/9/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO