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 08/30/2024

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 000	INITIAL COMMENTS COMPLAINT # NJ 176547 CENSUS: 192 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 VISIT.	F 000		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		9/18/24

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

Electronically Signed | 09/19/2024

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
	315157	A. BUILDING _____ B. WING _____	C 08/30/2024

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 690	Continued From page 1 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ176547 CENSUS: 192 SAMPLE SIZE: 3 Based on observation, interview, and record review, it was determined that the facility failed to provide appropriate NJ Ex Order 26.4(b)(1) and [redacted] a [redacted] resident who required [redacted]. This deficient practice was identified for 1 of 3 residents reviewed for [redacted] and NJ Ex Order 26.4(b)(1) (Resident #2) and was evidenced by the following: According to the "Admission Record", Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) without [redacted], NJ Ex Order 26.4(b)(1), [redacted] and NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1). According to the Minimum Data Set (MDS), an	F 690	1. Resident #2 was immediately provided proper NJ Ex Order 26.4(b)(1). 2. All incontinent residents are at risk of being affected by this deficient practice. 3. All CNA's were in-service by Director of Nursing on 09/12/2024 regarding proper incontinent care. 4. Director of Nursing or designee will audit 4 incontinent residents a month for 3 months for proper incontinent care and bring results to quarterly QAPI meeting.	

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 08/30/2024

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 690	Continued From page 2	F 690		

assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) of [redacted] indicating that Resident # 2's [redacted] was NJ Ex Order 26.4(b)(1). The MDS also identified that the Resident #2 was NJ Ex Order 26.4(b)(1) of [redacted] and [redacted] and was NJ Ex Order 26.4(b)(1).

Review of Resident #2's Care Plan (CP) initiated on [redacted], under Focus: "Resident is NJ Ex Order 26.4(b)(1) related to [redacted]" Under Goal: "Resident will remain [redacted] and have [redacted]." Under Interventions: " Anticipate and meet the resident's needs."

A Care Plan (CP) initiated on [redacted], included a focus that "the resident is at risk [redacted] r/t [related to] NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1). Interventions included but were not limited to: "Assist with [redacted]

During a tour of the [redacted] floor with the [redacted]) on [redacted] at 10:00 a.m., Resident #2 was lying in bed with eyes closed. Resident #2's NJ Ex Order 26.4(b)(1) was [redacted]

During another observation at 11:09 a.m. with the assigned US FOIA (b)(6) Resident #2 was lying in bed with eyes opened. Resident #2 had NJ Ex Order 26.4(b)(1), one NJ Ex Order 26.4(b)(1) and one [redacted] Resident # 2 was NJ Ex Order 26.4(b)(1), and the [redacted] was NJ Ex Order 26.4(b)(1) through to the [redacted]

During interview at 12:14 p.m. with the assigned [redacted] indicated that his/her shift started at 7:00 a.m. and stated, "I take it for granted that the

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 08/30/2024

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 690	Continued From page 3	F 690		

previous shift [NJ Exec Order 26.4] the residents on their assignment on the previous shift." [US FOIA (b)] stated that it was the first time Resident #2 was [NJ Ex Order 26.4(b)] for this shift. [US FOIA (b)] further stated that it was important to [NJ Ex Order 26.4] residents when [NJ Ex Order 26.4] to keep NJ Ex Order 26.4(b)(1).

Interview with the UM at 11:16 a.m. revealed that [NJ Ex Order 26.4(b)(1)] care should be done three times per shift which is every two hours, and as needed. [U.S. FOIA (b) (6)] stated that the shift started at 7:00 a.m. [U.S. FOIA (b) (6)] further stated that it was not normal practice for Resident #2 to have NJ Ex Order 26.4(b)(1).

Interview with the U.S. FOIA (b) (6)) at 1:47 p.m. revealed that the process for [NJ Ex Order 26.4(b)(1)] care was for it to be done frequently throughout the shift and as needed. [U.S. FOIA (b) (6)] further stated that it was not the expectation for a resident to have NJ Ex Order 26.4(b)(1).

Review of the facility's policy titled "Incontinence/Perineal Care" with reviewed/revised date of 1/1/24, stated: "It is the practice of this facility to provide to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection, to the extent possible, and to prevent and assess for skin breakdown."

NJAC 8:39-27.2(h)

New Jersey Department of Health

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 08/30/2024

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 COMPLAINT # NJ 176547 CENSUS: 192 SAMPLE SIZE: 3 THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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

Electronically Signed | 09/19/24

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315157	A. Building B. Wing	9/27/2024

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 F0690 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 09/18/2024	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
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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	
8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO