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 _____	**08/06/2021**

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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on)8/02/21 and Morristown Post Acute Rehab and Nursing Center 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 is a 5-story building with a basement that was built in 80's. It is composed of Type I(332) construction. The facility is divided into 15 smoke zones.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on	K 222		10/31/21

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

Electronically Signed | 08/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING	K 222		

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K 222	Continued From page 2 ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/02/21, it was determined that the facility failed to provide exit doors in the means of egress designed such that the operation of the releasing device was independent of the release of another device. This deficient practice was evidenced by the following: During a tour of the facility in the presence of the facility's Maintenance Director from 10:00 AM to 2:00 PM, the surveyor observed 19 of 20 exit doors leading to the stairways equipped with a door handle lever or doorknob mechanism. The doors were locked with a delayed egress magnetic lock. To release the lock and open the doors required continuous pressure by pushing the doors, and, turning the door's handle lever or doorknob which was not a single action as required. This finding was observed in the following areas: Basement Floor - 3 of 4 doors with doorknobs. 2nd Floor - 3 doors with doorknobs and 1 with door handle lever. 3rd Floor - 3 doors with doorknobs and 1 with door handle lever. 4th Floor - 4 of 4 doors with door handled	K 222	K222 I. CORRECTIVE ACTION 1) A contract was signed with a door company to install panic bars on 19/20 doors in the following areas: Basement Floor □ 3 of 4 doors with doorknobs 2nd Floor □ 3 doors with doorknobs and 1 with door handle lever 3rd Floor □ 3 doors with doorknobs and 1 with door handle lever 4th Floor □ 4 out of 4 doors with door handled lever 5th Floor □ 4 out of 4 doors with door handle lever 2) 3rd floor west wing door was repaired to ensure it opens within 30 seconds of initiating the delayed egress magnetic lock. II. IDENTIFY AT RISK RESIDENTS All residents have the potential to be affected. III. SYSTEMIC CHANGE The Safety Officer and maintenance staff received education regarding 1) the requirement to provide exit doors in the means of egress designed such that the operation of the releasing device	

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K 222	Continued From page 3 lever. 5th Floor - 4 of 4 doors with door handle lever. The failure to proceed through the door without one single action could impede or prevent emergency use of such means of egress. Also, during the tour the surveyor conducted an emergency egress test of the exit doors and revealed that the exit door located on the 3rd floor West Wing failed to opened within 30 seconds of initiating the delayed egress magnetic lock. These findings were verified by the facility's Maintenance Director during interviews during the observations. The facility's Administrator was informed of these findings during the Life Safety Code survey exit conference at 2:30 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.1, 7.2.1	K 222	be independent of the release of another device and 2) the requirement for exit doors to open within 30 seconds of initiating the delayed egress magnetic lock. IV. MONITOR CORRECTIVE ACTION The Safety Officer and maintenance staff check all egress doors with magnetic locks on a monthly basis and report concerns and occurrences quarterly to ensure the facility protocol is followed regarding operation of releasing means of egress devices. This review includes reporting findings at the Monthly Safety Meeting. The Safety Officer will audit logs for three months to ensure the facility protocol is followed. Results will be reported at the monthly QA meeting by the Administrator x 3 months.	
K 225 SS=C	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/02/21, it was determined that the facility failed to provide	K 225	K225 I. CORRECTIVE ACTION	10/31/21

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K 225	Continued From page 4 stair tread marking stripe applied as a material that is integral with the nosing of each step. This deficient practice was evidenced by the following: During a tour of the building from 10:00 AM to 12:00 PM in the presence of the facility's Director of maintenance, the surveyor's observation revealed 4 of 4 stairwells did not have a tread marking stripe on each step. This was observed in all 4 stairwells leading from the 5th to 1st and basement floors. This finding was verified by the facility's Physical Plant Manager during the observation. The facility's Administrator was informed of this finding during the Life Safety Code survey exit conference at 2:30 PM. NJAC 8:31.2(e) NFPA 101:2012 - 19.2.2.3, 7.2.2	K 225	Stair tread marking stripes applied to each step in 4 of 4 stairwells leading from the 5th to the 1st and basement floors. II. IDENTIFY AT RISK RESIDENTS All residents have the potential to be affected. III. SYSTEMIC CHANGE The Safety Officer and maintenance staff received education regarding the requirement to provide stair tread marking stripes applied as a material that is integral with the nosing of each step. IV. MONITOR CORRECTIVE ACTION The Safety Officer and maintenance staff check all stairways on a monthly basis and report concerns quarterly to ensure the facility protocol is followed regarding stair tread marking stripes. This review includes reporting findings at the Monthly Safety Meeting. The Safety Officer will audit logs for three months to ensure the facility protocol is followed. Results will be reported at the monthly QA meeting by the Administrator x 3 months.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced	K 281		10/31/21

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K 281	Continued From page 5 by: Based on observation and interview on 08/02/21, it was determined that the facility failed to provide automatic emergency illumination that would automatically operate along a means of egress. This deficient practice was evidenced by the following: During a tour of the building from 10:00 AM to 2:00 PM in the presence of the facility's Maintenance Director, the surveyor conducted a test of the emergency lighting on floors 1 through 5. The surveyor's tested the corridor lights by turning them off via a light switch and observed that the corridor lights did not remained on in 2 of 3 Wings on the 3rd floor and 3 of 3 Wings on the 2nd and 1st floor each. Also, the surveyor observed that the corridors were not equipped with emergency battery pack lights which would automatically immediately illuminate the area upon loss of electrical power. This finding was verified by the Maintenance Director during the observations who revealed that only the recently renovated sections of the building was provided with continuous emergency lighting in the corridors. The facility's Administrator was informed of this finding during the Life Safety Code survey exit at 2:30 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.8, 7.8.1.1, 7.8.1.2	K 281	K281 I. CORRECTIVE ACTION Corridor lights on 2 of 3 wings on the 3rd floor and 3 of 3 wings of the 2nd and 1st floor will be equipped with emergency battery pack lights. II. IDENTIFY AT RISK RESIDENTS All residents on the 3rd, 2nd and 1st floors have the potential to be affected. III. SYSTEMIC CHANGE The Safety Officer and maintenance staff received education regarding the requirement 1) for illumination of means of egress, including exit discharge, shall be either continuously in operation or capable of automatic operation without manual intervention and 2) to provide automatic emergency illumination that would automatically operate along a means of egress and 3) that the corridors need to be equipped with emergency battery pack lights which would automatically immediately illuminate the area upon loss of electrical power. IV. MONITOR CORRECTIVE ACTION The Safety Officer and maintenance staff check all corridor lights on each floor on a monthly basis and report illuminating concerns quarterly to ensure the facility protocol is followed regarding Illumination of Means of Egress. This review includes reporting findings at the Monthly Safety Meeting. The Safety Officer will audit logs	

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K 281	Continued From page 6	K 281	for three months to ensure the facility protocol is followed. Results will be reported at the monthly QA meeting by the Administrator x 3 months.	
K 351 SS=E	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. 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 observation and interview on 08/02/21, it was determined that the facility failed to provide complete sprinkler coverage in all parts of the building. This deficient practice was evidenced by the following: The exterior canopy located on the 1st floor and leading to the designated smoking area was	K 351	I. CORRECTIVE ACTION A metal (noncombustible) canopy was installed in the first-floor canopy area. II. IDENTIFY AT RISK RESIDENTS All residents have the potential to be affected. III. SYSTEMIC CHANGE The Safety Officer and maintenance staff	10/25/21

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K 351	Continued From page 7 attached to the building. The facility was unable to provide documentation evidencing its fire resistant rating. Also, the canopy extended more than 4-feet measuring 20-feet by 32-feet and was not equipped with automatic sprinkler heads. These findings were verified by the facility's Maintenance Director in interviews during the observations. The facility's Administrator was informed of these findings during the life Safety Code survey exit conference at 2:30 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.3.5.1	K 351	received education regarding the requirements for 1) Nursing Homes to be protected throughout by an approved automatic sprinkler system in accordance with NFPA, standard for the installation of sprinkler systems. 2) Balconies extending more than 4 feet and measured 12-feet by 22-feet to be equipped with automatic sprinkler heads. 3) Facilities to provide documentation evidencing its fire rating for exterior canopies attached to the building. 4) Canopies extending more than 4-feet measuring 20-feet by 32-feet to be equipped with automatic sprinkler heads. IV. MONITOR CORRECTIVE ACTION The Safety Officer and maintenance staff check all balconies and canopies monthly on each floor and report concerns quarterly to ensure the facility protocol is followed regarding Sprinkler System Installation. This review includes reporting findings at the Monthly Safety Meeting. The Safety Officer will audit logs for 3 months to ensure the facility protocol is followed. Results will be reported at the monthly QA meeting by the Administrator x3 months.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		9/20/21

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K 353	Continued From page 8 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/02/21, it was determined that the facility failed to ensure that all parts of their automatic sprinkler system was maintained in operable. This deficient practice was evidenced by the following findings: Automatic sprinkle heads were not free of impediments which would prevent them from extinguishing fire. At 2:00 PM, the surveyor and the facility's Maintenance Director toured the 1st floor subacute unit and new resident rehabilitation gym currently under extensive renovation/construction. The surveyor observed 6 of 9 automatic sprinkle heads in the subacute unit covered with a orange plastic cap to prevent them from accidentally activating. The surveyor observed the same device on all the automatic sprinkler heads (approximately 12) in the rehabilitation gym. The surveyor noted that both areas were not occupied	K 353	K353 I. CORRECTIVE ACTION Orange plastic caps were removed from 6 of 9 automatic sprinkler heads in the subacute unit additional orange plastic caps were removed from all the automatic sprinkler heads (approximately 12) in the rehabilitation gym. II. IDENTIFY AT RISK RESIDENTS All residents have the potential to be affected. III. SYSTEMIC CHANGE The Safety Officer, maintenance staff, Construction Project manager and construction crew received education regarding the requirements: 1) For the Facility to ensure that all parts of their automatic sprinkler system were maintained in accordance with NFPA standards for the Inspection, Testing, and maintenance of Water-based Fire	

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K 353	Continued From page 9 by contractors during the observations. An interview with the Maintenance Director during the observations confirmed the above, revealed that the contractors did not remove the devices at the end of the work day and, the facility did not ensure that the devices were removed after the contractors left at the end of the work day. NJAC 8:39-31.2(e) NFPA 101:2012 - 9.7.5 NFPA 25	K 353	protection Systems. 2) Automatic sprinkler heads must always remain free of impediments which would prevent them from extinguishing fire. The facility designated the foreman of the construction project to confirm the safety caps are removed after the constructions team leaves for the day. IV. MONITOR CORRECTIVE ACTION The Safety Officer and maintenance staff check all Fire Sprinkler Heads monthly on each floor and report concerns quarterly to ensure the facility protocol is followed regarding Sprinkler System – Maintenance and Testing. Construction Crews are required to sign-out only after assuring sprinkler head covers are removed. This review includes reporting findings at the Monthly Safety Meeting. The Safety Officer will audit logs for 3 months to ensure the facility protocol is followed. Results will be reported at the monthly QA meeting by the Administrator x3 months.	

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 01 - MAIN BUILDING 01 B. Wing Y2	1/24/2022 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	10/31/2021	LSC K0225	10/31/2021	LSC K0281	10/31/2021
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0351	10/25/2021	LSC K0353	09/20/2021	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	
8/6/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO