

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

PRINTED: 12/07/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315157	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2020
NAME OF PROVIDER OR SUPPLIER MORRISTOWN POST ACUTE REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 #: NJ135483, NJ136577, NJ139935, NJ140538 and NJ137658 Census: 144 Sample Size: 7 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		1/11/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/11/2021

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.

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F 609	<p>Continued From page 1</p> <p>Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 139935</p> <p>Based on interviews, record review, and facility policy review, it was determined that the facility failed to implement their policy to report an allegation of staff to resident physical abuse to local law enforcement agency, for 1 of 4(Resident #5) residents reviewed for abuse and misappropriation of property.</p> <p>Findings included:</p> <p>1. According to the Medical Record on [REDACTED], Resident #5 was admitted with diagnoses including [REDACTED].</p> <p>A Minimum Data Set (MDS), an assessment tool dated [REDACTED], revealed the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of [REDACTED]. The MDS indicated Resident #5 required limited assistance of one staff person for bed mobility, transfers, dressing, toilet use, and personal hygiene. The resident was independent with eating and required only set-up assistance, and had no physical or verbal behavioral symptoms directed towards others.</p> <p>On 12/02/2020 at 11:24 AM, Resident #5 was interviewed. The resident reported on 10/28/20, he/she asked the Licensed Practical Nurse (LPN #1) for his/her medication because several minutes up to an hour had passed without</p>	F 609	<p>How will corrective action be accomplished for those residents found to be affected by deficient practice?</p> <p>Education was provided to nursing staff /administration about expectation of notifying law enforcement in the event of abuse allegation.</p> <p>How will facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents Have the potential to be affected What measures will be will be put in place or systemic changes made to ensure that the deficient practice will not occur?</p> <p>Staff in-services and education was provided. Unit managers and Nursing supervisors will notify Administrator/ DON and call police for all allegations of staff to resident abuse. Police report number will be included on AAS-45 when reporting event to DOH</p> <p>How will facility monitor its corrective actions to ensure the deficient practice will not recur? DON or designee will audit completion of notification of proper agencies and documentation (AAS-45) for all</p>		

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F 609	<p>Continued From page 2</p> <p>receiving them. Resident #5 reported the staff member replied, "I sent you to the hospital before and I'm going to send you again," then punched the resident in the chest. The resident said the police were not called.</p> <p>A nursing note dated 10/28/2020 at 8:55 PM, by LPN #1, revealed an encounter with the resident that read as follows, "CNA [certified nursing assistant] notified me that resident is requesting [redacted] medication [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] was previously given at 6 pm and not due until 10 pm. I went into resident's room to explain that to [him/her] and [he/she] asked me for [redacted] instead and [his/her] [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]. Resident verbalized 'you are the [profanity] person who is responsible for sending me to the hospital that I then needed surgery...it is all your fault.'" I responded why and the resident started becoming more angry and using all kinds of profanities. I turned my back to exit the room and the resident threw the IV [intravenous] pole at me and hit me in the right arm creating a small skin tear that started bleeding. Resident then called [his/her] [family member] and told them that I punched [him/her] in the chest and that they need to call the police to come and arrest me. Supervisor called and made aware of the incident.</p> <p>A nursing note dated 10/28/2020 at 9:00 PM, by Nursing Supervisor #2 revealed the following; "Notified by [redacted] nursing that resident was accusing attending nurse of punching [him/her] in the chest. Spoke with attending nurse and he stated that resident was requesting [his/her] [redacted] NJAC 8:43E medication and [redacted] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] and started getting angry and verbally abusive with the nurse</p>	F 609	<p>allegations of staff to resident abuse. Results of the data will be analyzed and reported to the QAPI committee quarterly</p>		

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F 609	<p>Continued From page 3</p> <p>and the resident threw the iv [sic] pole at the nurse and hit him in the right arm. Resident is staing [sic] [he/she] did not hit the nurse with the IV pole, but the nurse punched him in the chest. Assessed resident's chest area; no discoloration, redness, swelling, or bruising noted. Resident telephoned [his/her family member] and wanted them to notify the police to come and 'arrest' the attending nurse for punching [him/her]. Spoke to [resident's family members] and they were made aware that no marking was noted on resident's chest, but that attending nurse did have a skin tear with frank blood on his right arm. [Family members] were made aware that resident does have a history of explosive, abusive, inappropriate, manipulative behavior toward nursing staff. DON called and made aware. Attending nurse was told change assignment in this room."</p> <p>The Administrator and the Chief Nursing Officer were interviewed on 12/03/2020 at 3:11 PM. The Administrator said he did not have a police report on file for the 10/28/20 abuse allegation made by Resident #5. The Administrator said he did not report the alleged staff to resident physical abuse to the police.</p> <p>The Abuse Investigation and Reporting Policy, last revised 09/2020, included, in part: "Reporting: All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator or his/her designee, to the following persons or agencies; The State licensing /certification agency responsible for surveying/licensing the facility; The local/State</p>	F 609			

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F 609	Continued From page 4 Ombudsman; The resident's Representative (Sponsor) of Record; Law enforcement officials; and, The resident's attending Physician." NJAC 8:39- 5.1(a)	F 609			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315157	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 1/12/2021	Y3
NAME OF FACILITY MORRISTOWN POST ACUTE REHAB AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 F0609	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 483.12(c)(1)(4)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	01/11/2021	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 _____	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/3/2020

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