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	03/08/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on observation, record review, interview, and United States (U.S.) Food and Drug Administration (FDA) dish sanitation recommendations, the facility failed to ensure 1 of 1 dish machine and 1 of 1 three-compartment sink were utilized in accordance with FDA guidance to minimize the potential for foodborne illness. Specifically, the facility failed to ensure the low-temperature dish machine achieved recommended temperatures, failed to ensure sanitizer testing supplies were not expired, and failed to maintain the chemical concentration of sanitizer in the three-compartment sink. The failed practices had the potential to affect 194 residents who received meals from the dietary department out of a total census of 199 residents. Findings included: Chapter 4 of the U.S. FDA 2022 Food Code indicated, ,d+[DATE].110 Mechanical Warewashing Equipment, Wash Solution Temperature (B) The temperature of the wash solution in spray-type warewashers that use chemicals to sanitize may not be less than 49 C [Celsius] (120 F. [Fahrenheit]). The Food Code also specified, ,d+[DATE].114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation - Temperature, pH [potential of Hydrogen], Concentration, and Hardness. (A) A chlorine solution shall have a minimum temperature based on the concentration and the pH of the solution as listed in the following chart: For a concentration range of 25 to 49 milligrams per liter (mg/L), the chart indicated the minimum temperature was to be 49 degrees C or 120 degrees F. A continuous observation conducted on [DATE] from 2:30 PM to 2:42 PM revealed the following: Dietary Aide (DA) #21 was standing at the three-in-one compartment sink washing pots, pans, and serving utensils. Dietary #21 had the sanitizing portion of the sink filled with large baking pans submerged in a fuchsia-colored liquid. He indicated he did not know about the chemicals for the sink and had not checked them. Dietary Supervisor (DS) #23 walked over to the sink and stated she was responsible for checking the sanitizer. DS #23 used a chemical test strip to test the solution in the sanitizer. The test strip indicated 400 to 500 parts per million (PPM). DS #23 stated the concentration should be 200 PPM. (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	DS #23 then accompanied the surveyor to observe the dish machine. The manufacturer of the machine was unable to be determined at this time. DA #20 was using the dish machine to run a rack of miscellaneous dishes off the metal table. The temperature gauge on the dish machine registered 110 degrees F. during the final rinse cycle. DA #20 indicated he had not checked the temperature, had not been taught to do so, and that the DS was responsible for checking the temperatures. DS #23 used a chlorine testing strip to check the chemical concentration following a rack of dishes being run through the dish machine. The first test strip indicated the concentration of the solution in the dish machine was zero. DS #23 obtained another chemical test strip and placed it in the dish machine, and the test strip continued to indicate zero. Following third test strip reading zero, the surveyor requested the container of chlorine test strips, which revealed the expiration on the package was [DATE]. DS #23 indicated she did not know how the strips could be expired considering how many of the strips they used and asked DS #22 to obtain a new package. DS #22 retrieved a new unopened container of test strips and handed it to DS #23. DS #23 obtained a test strip from the new container, ran a rack of miscellaneous dishes through the dish machine, then dipped the test strip into the liquid solution inside the machine. The new test strip continued to indicate zero. DS #23 was asked what she would do next, and she stated she did not know, because this had never happened before. DS #23 and the surveyor checked the chemical dispenser for the machine and noted there was very little product remaining in the container. During an interview on [DATE] at 3:45 PM, the Regional Director of Clinical Compliance (RDCC) stated she was unable to obtain any policies or competencies for the staff for the dietary department because the Dietary Manager (DM) was not in the facility at that time. During a telephone interview on [DATE] at 4:05 PM, the DM stated he was not certain of how to identify the manufacturer of the dish machine if the information was not listed on the machine. He indicated the machine should reach a minimum temperature of 135 degrees F. for the final rinse cycle. The DM stated at times, the water in the dietary department did not get hot enough and that this had been repaired before. He stated the dish machine chlorine test strips should read between 50 and 100 PPM. The DM stated the three-in-one compartment sink sanitizer should be changed every two hours and that if the chemical concentration was greater than 200, the sink should be emptied and the solution redone and rechecked. He stated he needed to contact the Director of Nursing (DON) or Administrator to tell them the facility needed to start using disposable dishes until the dish machine was fixed. The facility Diet Type Report, dated [DATE], indicated there were 194 residents who received meals from the kitchen. During an interview on [DATE] at 12:50 PM, the RDCC stated the Administrator would be unavailable for any interviews. At 4:23 PM, the RDCC stated she had looked all over the dish machine and had been unable to determine the manufacturer of the machine.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51682 Based on observation, record review, interview, facility policy review, review of Centers for Disease Control and Prevention (CDC) guidance, and review of the Centers for Medicare and Medicaid Services (CMS) Quality, Safety and (&) Oversight Group (QSOG) memoranda, the facility failed to ensure CDC guidance and the facility's infection prevention and control (IPC) policies were promptly and consistently implemented, as evidenced by: 1) failure to ensure staff donned the appropriate personal protective equipment (PPE) while caring for 3 (Residents #1, #2, and #3) of 3 residents reviewed for enhanced barrier precautions (EBP. 2) failure to ensure staff donned the appropriate PPE when entering the room to deliver and set up a meal tray for 1 (Resident #4) of 3 residents reviewed for transmission-based precautions and failed to perform appropriate hand hygiene between delivering meals to Residents #4, #5, and #6. 3) failure to ensure a vaccination was promptly administered after consent was obtained for 1 (Resident #9) of 5 residents reviewed for vaccinations. 4) failure to ensure a resident who was symptomatic for respiratory syncytial virus (RSV) was promptly tested upon receipt of a physician order for testing for 1 (Resident #11) of 8 residents reviewed for RSV. 5) failure to correctly and consistently conduct and document contact tracing on residents and staff when 7 (Residents #12, #10, #14, #15, #16, #17, and #18) of 8 residents reviewed for COVID-19 tested positive for COVID-19. The failure to implement appropriate infection control measures had the potential to affect all 199 residents residing in the facility. Findings included: 1. QSOG Memorandum QSO-24-08-NH, Enhanced Barrier Precautions in Nursing Homes, dated 03/20/2024, indicated, Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The memo also specified, EBP are indicated for residents with any of the following: - Infection or colonization with a CDC-targeted MDRO [multidrug-resistant organism] when Contact Precautions do not otherwise apply; or - Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1.a. An Admission Record indicated the facility admitted Resident #1 on 06/2018 and readmitted the resident on 07/2021. According to the Admission Record, the resident had a medical history that included diagnoses of obstructive and reflux uropathy, mechanical complication of nephrostomy catheter, and need for assistance with personal care. Resident #1's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/24/2024, revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident had an indwelling catheter and was dependent on staff for bathing, toileting hygiene, and bed-to-chair transfers. Resident #1's Care Plan Report included a focus area revised 09/19/2024 that indicated Resident #1 was at risk for infection requiring enhanced barrier precautions related to a nephrostomy. Interventions directed staff to use a gown and gloves during high-contact activities, such as dressing, hygiene, transferring, bathing/showering, changing linens, device care, wound care, and therapy and to perform hand hygiene prior to and after providing care to the resident. Resident #1's Kardex revealed the resident required enhanced barrier precautions and directed staff to wear a gown and gloves during high contact activities, such as dressing, hygiene, toileting, transferring, bathing/showering, changing linens, device care, wound care, and therapy and to perform hand hygiene prior to and after providing care. Resident #1's Order Summary Report included an order dated 10/20/2024 for enhanced barrier precautions related to a nephrostomy. During an observation on 03/08/2025 at 9:26 AM, unidentified staff members entered Resident #1's room without donning PPE. At 9:30 AM, a follow-up observation revealed Certified Nurse Aide (CNA) #7 in Resident #1's room assisting the resident to transfer from the bed to a wheelchair. During an interview conducted when CNA #7 exited Resident #1's room on 03/06/2025 at 9:33 AM, CNA #7 stated she had just completed morning care for Resident #1, which included incontinence care, bathing, dressing, and transferring. CNA #7 stated she should wear a gown and gloves when providing care to a resident on EBP, but since there was no basket (clarified to mean PPE cart) outside the resident's room, the EBP signage that was posted should have been taken down. She acknowledged that Resident #1 had a nephrostomy tube in place but stated she had not been instructed that the resident required EBP. She again stated Resident #1 did not have a basket, so she did not wear a gown while providing care to the resident. During a telephone interview on 03/08/2025 at 1:00 PM, the Director of Nursing (DON) stated staff who were providing direct care to residents on EBP were required to wear a gown and gloves. The DON indicated CNA #7 should have donned a gown and gloves before providing morning care to Resident #1. During an interview on 03/08/2025 at 12:50 PM, the Regional Director of Clinical Compliance (RDCC) stated the Administrator would be unavailable for any interviews. 1.b. An Admission Record indicated the facility admitted Resident #2 on 04/2022 and readmitted the resident on 08/2023. According to the Admission Record, the resident had a medical history that included diagnoses of end stage renal disease and dependence on renal dialysis. (continued on next page)

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	315157	A. Building B. Wing	03/08/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #2's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/05/2025, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident required substantial/maximal assistance for bathing and bed-to-chair transfers and received dialysis while a resident. Resident #2's Care Plan Report included a focus area revised 01/02/2025 that indicated Resident #2 was at risk for infection requiring enhanced barrier precautions related to colonization with a targeted multi-drug resistant organism (MDRO). Interventions directed staff to use a gown and gloves during high-contact activities, such as dressing, hygiene, transferring, bathing/showering, changing linens, device care, wound care, and therapy and to perform hand hygiene prior to and after providing care to resident. Resident #2's Order Summary Report included an order dated 04/01/2024 for enhanced barrier precautions related to a central line. An observation on 03/06/2025 at 10:06 AM revealed that signage was posted outside Resident #2's room indicating enhanced barrier precautions were required and a gown and gloves were required for transfers. Certified Nurse Aide (CNA) #10 retrieved supplies from a linen cart outside Resident #2's room, and CNA #13 followed her into the room pushing a shower chair. Neither CNA donned a gown prior to entering the room. CNA #13 exited the room wearing a pair of gloves and retrieved additional linen from the linen cart in the hallway, then returned to the room. CNA #10 opened the door wearing gloves. Resident #2 was observed to be seated in the shower chair when the door was opened. CNA #10 proceeded to push the resident in the shower chair into the hallway, then propelled the resident down the hallway to the shower room. During an observation on 03/06/2025 at 10:32 AM, CNA #10 and CNA #13 returned Resident #2 to their room after giving the resident a shower. The CNAs donned gowns and gloves prior to assisting the resident further. During an interview on 03/06/2025 at 10:33 AM, CNA #10 stated she and CNA #13 had transferred Resident #2 from the bed to a shower chair wearing only gloves but would don a gown and gloves to put the resident back to bed and dress the resident. She stated since she was not providing any care other than transferring during the surveyor's initial observation, she did not need a gown just to transfer the resident from bed to the shower chair. She stated she had received training on EBP but did not realize transferring was included in the activities for which a gown and gloves would be required. CNA #10 observed the signage posted outside Resident #2's door and stated she should have donned a gown and gloves before transferring the resident. During an interview on 03/06/2025 at 10:58 AM, CNA #13 revealed she received training on EBP that directed her to don a gown and gloves during high contact care. CNA #13 acknowledged she did not wear a gown while transferring Resident #2 from the bed to the shower chair. CNA #13 stated she was not aware EBP required a gown for transfers. CNA #13 observed the EBP signage posted outside Resident #2's door and stated she should have donned a gown and gloves prior to transferring the resident. During an interview on 03/06/2025 at 10:20 AM, Licensed Practical Nurse (LPN) #8 stated the EBP signage posted for Resident #2's room was for Resident #2 due to the resident being on dialysis. (continued on next page)

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	315157	A. Building B. Wing	03/08/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/06/2025 at 10:28 AM, CNA #9 stated Resident #2 required dialysis and was on EBP. She stated staff were to wear a gown and gloves while caring for Resident #2. During a telephone interview on 03/08/2025 at 1:00 PM, the Director of Nursing (DON) stated staff who were providing direct care to residents on EBP were required to wear a gown and gloves. The DON indicated CNA #10 and CNA #13 should have donned a gown and gloves before providing care to Resident #2. During an interview on 03/08/2025 at 12:50 PM, the Regional Director of Clinical Compliance (RDCC) stated the Administrator would be unavailable for any interviews. 1.c. A facility policy titled, Categories of Transmission-Based Precautions, revised 01/2025, included a section under each type of precautions that was titled, Resident Transport which indicated, If the resident is transported to another unit within Facility or to another facility, the Infection Control Coordinator (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. Facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions. An Admission Record indicated the facility admitted Resident #3 on 06/2012 and readmitted the resident on 06/2021. According to the Admission Record, the resident had a medical history that included diagnoses of end stage renal disease and dependence on renal dialysis. Resident #3's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/05/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident required supervision or touch assistance for bed-to-chair transfers and received dialysis while a resident. Resident #3's Care Plan Report included a focus area revised on 02/28/2025 that indicated Resident #3 was at risk for infection requiring enhanced barrier precautions related to colonization with a targeted multi-drug resistant organism (MDRO), an indwelling catheter, and a chronic wound. Interventions directed staff to wear a gown and gloves during high-contact activities, such as dressing, hygiene, transferring, bathing/showering, changing linens, device care, wound care, and therapy and to perform hand hygiene prior to and after providing care to the resident. Resident #3's Order Summary Report contained an order dated 02/28/2025 for enhanced barrier precautions related to MDRO colonization, an indwelling catheter, and a chronic wound. An observation on 03/06/2025 at 10:45 AM revealed Medical Transport Staff (MTS) #11 and MTS #12 entering Resident #3's room with a stretcher to transport the resident to the dialysis center. The two staff transferred Resident #3 from the bed to the stretcher wearing a surgical mask, gloves, and no gown. Resident #3's door had signage posted indicating the resident required EBP and that a gown and gloves were required for transfers. During an interview on 03/06/2025 at 10:50 AM, Medical Transport #11 and Medical Transport #12 stated they were familiar with Resident #3 and transported the resident to dialysis every week. They stated they were not required to follow the posted EBP signage. Both staff observed and acknowledged the EBP signage outside Resident #3's room and stated they were only required to don PPE above what would be required for standard precautions if a resident was COVID-19 positive. (continued on next page)

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	315157	A. Building B. Wing	03/08/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/08/2025 at 1:00 PM, the Director of Nursing (DON) stated staff who were providing direct care to residents on EBP were required to wear a gown and gloves. The DON indicated MTS #11 and MTS #12 did not work for him so were not required to wear the same PPE as his staff. During an interview on 03/08/2025 at 12:50 PM, the Regional Director of Clinical Compliance (RDCC) stated the Administrator would be unavailable for any interviews. ------ 2. A facility policy titled, Infection Control Guidelines for All Nursing Personnel, revised 01/2025, indicated Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent the spread of infection. a. When transmission-based precautions are required, a sign will be placed at the resident's doorway directing individual to see the nurse before entering the room. Without violating HIPAA [Health Insurance Portability and Accountability Act] regulations, the nurse will ensure that any individual entering the room wears appropriate PPE. A facility policy titled, Categories of Transmission-Based Precautions, revised 01/2025, indicated, 1. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection. The policy also specified, Contact Precautions - In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The policy indicated, c. Gloves and Handwashing - (1) In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room and (3) Remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or waterless antiseptic agent. The policy further indicated, Gown - (1) In addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, non-sterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment. Remove the gown and perform hand hygiene before leaving the resident's environment. A facility policy titled, Clostridium Difficile revised 01/2025 indicated 3. The primary reservoirs for C. [Clostridium] difficile are infected people and surfaces. Spores can persist on resident care items and surfaces for several months and are resistant to some common cleaning and disinfection methods. 4. C. Difficile is transmitted by the fecal-oral route. Therefore, any resident care activity that involves contact with a resident's mouth when hands or instruments are contaminated may provide an opportunity for transmission. The policy also specified, 10. Residents with diarrhea associated with C. difficile (i.e. [that is], residents who are colonized and symptomatic) will be placed on Contact Precautions. a) Healthcare workers will wear gloves and gowns upon entering the room of a resident with C. difficile infection and will remove gown and gloves prior to exiting the room. and Hand washing with soap and water is superior to ABHR [alcohol-based hand rub] for the mechanical removal of C. difficile spores from hands. 12. Glove use when caring for residents with C. difficile, washing hands with soap and water upon exiting the room of a resident with C. difficile infection AND strict adherence to hand hygiene in general is considered best practice. An Admission Record indicated the facility admitted Resident #4 on 03/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of recurrent enterocolitis due to Clostridium difficile. (continued on next page)

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	315157	A. Building B. Wing	03/08/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #4's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/08/2025, revealed the resident's assessment was in progress. Section C of the assessment in progress indicated Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Section I of the assessment in progress indicated Resident #4 had an active diagnosis of recurrent enterocolitis due to Clostridium difficile (C. diff). Resident #4's Care Plan Report included a focus area revised 03/05/2025 that indicated Resident #4 had a gastrointestinal (GI) infection related to C. diff. Intervention directed staff to maintain isolation precautions as indicated. Resident #4's Order Summary Report contained an order dated 03/05/2025 for transmission-based precautions (TBP)/contact precautions for C. difficile and for staff to wash hands prior to exiting the patient area. A continuous observation on 03/06/2025 from 11:27 AM to 11:33 AM revealed Hospitality Aide (HA) #16 delivering meal trays on a unit of the 500 Hall. HA #16 retrieved a meal tray from the service cart and entered Resident #4's room. Signage was posted outside the resident's room that indicated, Special Contact Precautions and that a gown and gloves were required to enter the room. Special instructions on the signage indicated hand hygiene must be performed using soap and water. Do not use hand sanitizer. HA #16 adjusted Resident #4's bedside table and set the meal tray in front of Resident #4 before exiting the room without washing her hands. HA #16 returned to the meal service cart without performing hand hygiene and retrieved Resident #5's meal tray, entered Resident #5's room, and placed the meal tray on the overbed table before exiting the room. Still without washing her hands, HA #16 returned to the service cart to retrieve Resident #6's meal tray, then entered Resident #6's room to deliver the resident's meal tray. Review of Resident #5's care plan and physician's orders revealed the resident was at risk for infection and required EBP related to a tracheostomy and PleurX catheter (a small tube inserted into the chest to drain fluid from around the lungs). Review of Resident #6's care plan and physician's orders revealed the resident was at risk for infection and required EBP related to a chronic wound. During an interview on 03/06/2025 at 11:28 AM, HA #16 stated she should have performed hand hygiene using alcohol-based hand rub (ABHR) when she exited Resident #4's room. She stated she did not need to wear a gown and gloves nor perform hand hygiene with soap and water before exiting the room because she was only delivering the meal tray. HA #16 then observed and acknowledged the signage posted outside Resident #4's door, which indicated staff were to don a gown and gloves before going into Resident #4's room and perform hand hygiene using soap and water when exiting. HA #16 also stated she should have performed hand hygiene using ABHR between delivering meal trays to Resident #5 and Resident #6. During an interview on 03/06/2025 at 11:34 AM, Licensed Practical Nurse (LPN) #14 stated Resident #4 was on special contact precautions for C. diff and that HA #16 should have donned a gown and gloves before entering the room and washed her hands with soap and water. LPN #14 also stated meal trays for residents on TBP were supposed to be delivered last. (continued on next page)

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	315157	A. Building B. Wing	03/08/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/06/2025 at 11:37 AM, the Director of Nursing (DON) and Administrator were made aware of the observations concerning Resident #4. Both the DON and Administrator acknowledged Resident #4 was on special contact precautions and both stated HA #16 should have donned PPE according to the signage and washed her hands using soap and water when exiting the room. They both acknowledged that Resident #5 and Resident #6 were on EBP and stated HA #16 should have performed hand hygiene using ABHR between delivering their meal trays. --- 3. A facility policy titled, Coronavirus, Prevention and Control, revised 03/05/2025, indicated Vaccination 1. Each resident and staff member will be educated about and offered an FDA [U.S. Food and Drug Administration]-approved COVID vaccine unless the immunization is medically contraindicated or the resident or staff member has already been fully immunized. The policy also specified, The resident's medical record will include documentation that indicates: a. That the resident or resident representative was provided education regarding benefits and potential risks associated with COVID vaccine. b. Each dose of COVID vaccine administered to the residents, or c. If the resident did not receive the vaccine due to medical contraindication or refusal. An Admission Record indicated the facility admitted Resident #9 on 04/2022 and readmitted the resident on 01/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of acute osteomyelitis. Resident #9's significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/10/2025, indicated Resident #9 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS revealed Resident #9's COVID-19 vaccine was not up to date. Resident #9's Vaccine Consent Form - Multi-Vaccines revealed a consent was signed by the resident on 10/23/2024. The form indicated the resident circled Yes to receiving a COVID-19 (2024-2025) vaccine and a Respiratory Syncytial Virus (RSV) vaccine. As of 03/07/2025, Resident #9's Immunization Record indicated the resident received the RSV vaccine on 10/24/2024 but did not receive the COVID-19 (Moderna Spikevax Vaccine 24-25) until 02/12/2025. During an interview on 03/07/2025 at 11:00 AM, the Infection Preventionist acknowledged the delay in administering Resident #9's COVID-19 (2024-2025) vaccine and stated she was unsure why the vaccine was not administered until four months after the consent was signed. She stated the vaccine should have been administered as soon as possible. During an interview on 03/07/2025 at 11:30 AM, the Director of Nursing (DON) stated he was not sure why Resident #9's COVID-19 vaccine was not administered after the consent was signed but thought it was related to multiple hospital admissions during that time (see hospitalization information below). The DON indicated vaccines should be administered as quickly as possible after consent was obtained. Regarding Resident #9's history of hospitalization s: (continued on next page)

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	03/08/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A Discharge-return anticipated MDS, with an ARD of 06/27/2024, indicated the resident was discharged to a short-term general hospital on 06/27/2024. - An MDS with an ARD of 09/23/2024 indicated the resident's reentry date was 07/08/2024. There were no further MDS assessments that indicated subsequent hospitalization s until 01/06/2025. - A Discharge-return anticipated MDS, with an ARD of 01/06/2025, indicated the resident's most recent reentry date was 07/08/2024 and that the resident was discharged on [DATE] to a short-term general hospital. An Entry Tracking Record MDS with an ARD of 01/25/2025 indicated the resident returned to the facility on [DATE]. During an interview on 03/08/2025 at 12:50 PM, the Regional Director of Clinical Compliance (RDCC) stated the Administrator would be unavailable for any interviews. --- 4. A facility policy titled, Respiratory Syncytial Virus, Prevention and Control revised 01/2025 indicated 1. Residents who test positive for RSV infection should ideally be placed in a single person room. Limit transport and movement of the patient outside the room to medically essential purposes. 2. Residents who test positive for RSV infection should be placed on contact precautions for the duration of illness. The decision to discontinue transmission-based precautions should be made in consultation with infection preventionist and/or physician once symptoms have resolved. CDC online guidance titled, Viral Respiratory Pathogens Toolkit for Nursing Homes, dated 01/08/2025 and available at https://www.cdc.gov/long-term-care-facilities/hcp/respiratory-virus-toolkit/index.html, indicated, Test and Treat - Develop plans to provide rapid clinical evaluation and intervention to ensure residents receive timely treatment and/or prophylaxis when indicated. The policy also indicated, ACTION: RESPOND when a resident or HCP [healthcare personnel] develops signs or symptoms of a respiratory viral infection. When an acute respiratory infection is identified in a resident or HCP, it is important to take rapid action to prevent the spread to others in the facility. While decisions about treatment, prophylaxis, and the recommended duration of isolation vary depending on the pathogen, IPC [infection prevention and control] strategies, such as placement of the resident in a single-person room, use of a facemask for source control, and physical distancing, are the same regardless of the pathogen. An Admission Record indicated the facility admitted Resident #11 on 12/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of end stage renal disease. Resident #11's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/20/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. A Nursing Progress Note, dated 01/22/2025 at 7:06 PM, indicated Resident #11 complained of a cough and a loose bowel movement. According to the note, the resident was seen by the physician and new orders were received for a respiratory viral panel, COVID, and influenza testing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #11's Order Summary Report included a physician's order dated 01/22/2025 to collect a swab specimen for a respiratory panel to rule out infection. There was no documentation in the medical record to indicate the ordered specimen was collected until 01/24/2025. A laboratory report revealed a respiratory viral panel was collected on 01/24/2025 at 3:40 PM, with the results reported the same day at 8:34 PM and confirming that Resident #11 was positive for RSV. During an interview on 03/07/2025 at 11:00 AM, the Infection Preventionist indicated the facility collected the swab specimens for the respiratory panel labs and stated that they should be obtained upon receiving the order from the physician. During an interview on 03/07/2025 at 11:30 AM, the Director of Nursing stated labs should be obtained when the orders were received from the provider. ------ 5. A facility policy titled, Coronavirus, Prevention and Control, revised 03/05/2025, indicated, Regardless of vaccination status, staff who have had higher-risk exposure to a positive COVID case will be tested for COVID as soon as possible, but no sooner than 24 hours following exposure, again 48 hours later, and again 48 hours later (Day 1,3, and 5). The policy also specified, 3) Asymptomatic residents who have had close contact with a COVID case will be encouraged to wear source control for 10 days following exposure. Testing will be conducted on Day 1, Day 3, and Day 5 following day of exposure (Day 0). If results are positive, no further testing is needed, and the resident is to be placed on transmission-based precautions. The policy also indicated, c. An outbreak is defined as a new SARS-CoV-2 infection in any HCP [healthcare personnel] or any nursing-home onset SARS-CoV-2 infection in a resident. d. In the event of an outbreak, the facility will initiate contact tracing to identify residents or staff who may have had close contact (> [greater than or equal to] 15 min [minutes] of exposure within 6 feet, cumulative over 24 hours) or higher-risk exposure with the positive individual during the 48 hours prior to symptom onset / specimen collection. The policy also indicated, When close contacts are identified, HCP with higher risk exposure to a COVID-positive individual and residents who had close contact with the COVID-positive individual will be tested immediately. Repeat testing will be conducted on Day 1 following exposure and again on Day 3 and Day 5. Review of laboratory results revealed the following: - A laboratory report dated 01/26/2025 indicated Resident #10 was positive for COVID-19. - A laboratory report dated 01/28/2025 indicated Resident #12 was positive for COVID-19. - A laboratory report dated 01/29/2025 indicated Resident #14 was positive for COVID-19. - A laboratory report dated 01/30/2025 indicated Resident #15 was positive for COVID-19. - A laboratory report dated 02/02/2025 indicated Resident #16 was positive for COVID-19. - A laboratory report dated 02/10/2025 indicated Resident #17 was positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- A laboratory report dated 02/13/2025 indicated Resident #18 was positive for COVID-19. The facility's COVID-19 Outbreak Contact Tracing Log revealed the above COVID-19 outbreak started on 01/26/2025. Outbreak investigation #E-2025-30890 included contact tracing documentation for two residents and no staff. During an interview on 03/07/2025 at 11:00 AM, the Infection Preventionist indicated for contact tracing, she interviewed staff to find out if they wore a mask during care for residents who were positive for COVID-19 and determine if they needed to be tested . She stated most staff were determined by her not to be high-risk because they had not spent more than 15 minutes each time they encountered a COVID-positive resident. (This did not align with the facility's policy to consider high-risk exposure as greater than or equal to 15 minutes of exposure over a 24 hour period). The IP nurse stated and provided documentation that she conducted contact tracing for nurses assigned to the residents on the dates each resident tested positive, and on Days 3 and 5 after the exposure; however, she could not locate any documentation of contact tracing completed for the nurse aides and therapy staff who cared for the COVID-positive residents. During an interview on 03/07/2025 at 11:30 AM, the Director of Nursing indicated he had assigned the IP nurse to oversee all contact tracing and stated that to his knowledge, those items had been completed per guidelines. During an interview on 03/08/2025, the Regional Director of Clinical Compliance (RDCC) stated the Administrator would be unavailable for any interviews.