STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315236	A. BUILDING _____ B. WING _____	C 12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI POST ACUTE NURSING AND REHAB CENTER	**65 JAY STREET NEWARK, NJ 07103**

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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		
F 000	INITIAL COMMENTS Complaint #: NJ00159458, NJ00159211, NJ00159056, NJ00158923, NJ00158871, NJ00155764, NJ00151577, NJ00150854 Survey Date: 12/22/2023 Census: 346 Sample: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		1/16/24

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

Electronically Signed | 01/04/2024

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.

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F 584	Continued From page 1 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain resident's equipment and living areas in a clean and home like manner. This deficient practice was identified for 1 of 2 residents (Resident #171) reviewed for environment. This deficient practice was evidenced by the following: On 12/14/23 at 10:14 AM, the surveyor observed	F 584	1. The hole in the wall next to resident #171 was repaired. 2. All residents have the potential to be affected by this deficient practice. 3. Nurses, CNA's and housekeeping personnel have been in-serviced on timely reporting of environmental issues to the maintenance department. The maintenance department was reeducated	

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F 584	Continued From page 2 Resident #171 sitting up at the side of their bed. The resident's bed was positioned against the wall. Behind the resident the surveyor observed a precise square cut hole in the wall. The surveyor observed wall insulation peering out and a wire running from the hole down the wall, behind the resident's bed. The surveyor could not see the floor behind the resident's bed. Resident #171 stated there was something in the hole previously and whatever was there fell out. The resident stated it may have been like that for about four months. Resident #171 could not identify which staff members were aware about the hole in the wall. A review of Resident #171's electronic medical record revealed the following: According to the Admission Record (an admission summary) the resident was admitted to the facility with diagnoses that included but were not limited to, *Ex Order 26. 4B1* [redacted]. The Annual Minimum Data Set (MDS), an assessment tool to facilitate care, dated [redacted] indicated the facility assessed the resident's cognitive status using a *Ex Order 26. 4B1* [redacted]. The resident scored a [redacted] out of 15 which indicated that the resident was *Ex Order 26. 4B1* [redacted]. On 12/14/23 at 10:44 AM, the surveyor interviewed Certified Nursing Assistant #1 (CNA #1) who was assigned to care for Resident #171. CNA #1 stated she had never noticed the hole in the wall, that it could be something recent and the resident had not reported any concerns to staff.	F 584	on rounding to pay attention to detail ensuring a homelike environment is maintained. 4. 10 resident rooms with speakers next to their bed will be audited by the maintenance director/designee weekly x 4 then monthly x 3 to ensure proper placement and a homelike environment is maintained. Audit findings will be shared with the QAPI committee monthly x 4 for review.	

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F 584	Continued From page 3 On 12/14/23 at 11:02 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1) who was assigned to care for Resident #171. LPN #1 stated she did not notice the hole in the resident's wall. On 12/14/23 at 11:12 AM, the surveyor interviewed Licensed Practical Nurse Unit Manager #1 (LPN/UM #1) about the hole in the wall in the resident's room. LPN/UM #1 stated she was not aware about the hole in the resident's wall and stated staff should report issues to maintenance for it to be addressed. On 12/15/23 at 9:44 AM, the surveyor interviewed the Maintenance Director (MD), who stated the hole in the wall was for a speaker/audio device that was installed in the wall. He could not identify when or how it came out of the wall. The MD stated that maintenance only became aware of the issue after they were notified by the nursing staff earlier this week. On 12/19/23 at 9:50 AM, the surveyor informed the Director of Nursing (DON) and License Nursing Home Administrator about the concern of the hole in the wall located in Resident #171's room. The DON stated she was not aware of the hole in the wall. There was no additional information provided by the facility. A review of the facility's policy titled, "Quality of Life- Homelike Environment" updated on 10/2023, under Policy Statement read: "Residents are provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible."	F 584		

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F 584	Continued From page 4 Under Policy Interpretation and Implementation, it read: " ...2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: ... a. Cleanliness and order ..." N.J.A.C. 8:39-4.1 (a)11; 31.4 (a), (b); 31.8 (e)	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 2 of 38 residents, Resident #346 and #548 reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 12/18/23 at 12:38 PM, the surveyor reviewed the closed hybrid medical records for Resident #346, who was documented on the Ex Order 20. 4B1 Discharge MDS section A as "Discharge assessment-return not anticipated," "Unplanned" discharge to "Short-Term General Hospital . Review of the Admission Record (a one-page summary of important information about the	F 641	1. The MDS coding error was corrected for residents #346 and 548. 2. All residents who discharge have the potential to be affected by this deficient practice. 3. MDS personnel will be re-educated and in-serviced on proper coding for discharge residents. 4. Audit will be done by the MDS Director/designee weekly x 4 then monthly x 2 on 3 discharged residents to ensure they have been coded properly. Audit results will be shared with the QAPI committee monthly x 3 for review.	1/16/24

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F 641	Continued From page 5 patient) reflected Resident #346 was admitted to the facility on Ex.Order 26.4(b)(1) with diagnosis that included but were not limited to Ex Order 26. 4B1 [redacted]. Review of the Ex.Order 26.4(b)(1) 20:50 INTERDISCIPLINARY CARE Planning (IDCP) CONFERENCE NOTES Late Entry which documented: "Note Text: IDCP team met with resident to discuss admission MDS/Care plans. Resident is Ex.Order 26.4(b)(1) [redacted]. Resident is on Ex Order 26. 4B1, Ex Order 26. 4B1. Resident needs limited assistance with Ex Order 26. 4B1 [redacted]. Resident Practitioner Orders for Life Sustaining Treatment (POLST) is Full Code. Resident would like to transfer to another facility. Resident schedule transfer on Ex Order 26. 4B1..." Review of the Ex.Order 26.4(b)(1) Progress Note Text documented, "Resident discharged to another facility. All belongings taken. Left facility around 4:45pm in Ex.Order 26.4(b)(1)." According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 ... "According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 ... "For unplanned discharge includes, for example: Ex Order 26. 4B1 transfer of the resident to a Ex Order 26. 4B1 or an Ex Order 26. 4B1 [redacted] in order to either stabilize a condition or determine if an Ex Order 26. 4B1 admission is required based on Ex Order 26. 4B1 [redacted] evaluation; or Resident unexpectedly leaving the facility against medical advice; or	F 641		

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F 641	Continued From page 6 Resident unexpectedly deciding to go home or to another setting (e.g., due to the resident deciding to complete treatment in an alternate setting.)" On 12/19/23 at 10:11 AM, the surveyor discussed MDS coding with the Director of Nursing (DON) for Resident #346. The DON did not provide any further information related to this issue. On 12/19/23 at 10:53 AM, the surveyor reviewed the MDS coding error with the MDS Coordinator. The MDS Coordinator verified that she miscoded the Discharge MDS for resident #346 in error. The MDS Coordinator clarified that the discharge was planned to another facility. 2. On 12/14/23 at 2:31 PM, the surveyor reviewed the hybrid medical records for Resident #548, who was documented on the [redacted] Discharge MDS section A as "Discharge assessment-return anticipated," "Planned" discharge to "[redacted] Hospital." Review of the Admission Record reflected Resident #548 was admitted to the facility on [redacted] with diagnosis that included but were not limited to [redacted]. Review of the [redacted] Progress Note Text documented, "Today resident wants to go to the [redacted], at the moment the resident is not presenting [redacted] signs. [redacted]. MD made aware and order to transfer to the [redacted] for a [redacted]. Will continue monitoring."	F 641		

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F 641	Continued From page 7 On 12/19/23 at 10:11 AM, the surveyor discussed MDS coding with the Director of Nursing (DON) for Resident #548. The DON did not provide any further information related to this issue. On 12/19/23 at 10:53 AM, the surveyor reviewed the MDS coding error with the MDS Coordinator. The MDS Coordinator verified that she miscoded the Discharge MDS for resident #548 in error. The MDS Coordinator clarified that the discharge was unplanned to the [redacted].	F 641		
F 656 SS=D	NJAC 8:39-11.1, 11.2(e)(1) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		1/16/24

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F 656	Continued From page 8 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to develop a comprehensive, person-centered care plan (CP) for 3 of 35 residents reviewed for comprehensive care plans (Resident #171, #313, and #2). This deficient practice was evidenced by the following: 1. On 12/12/23 at 11:35 AM, the surveyor observed Resident #171 sitting up at the side of the bed in their room. The resident was Ex.Order 26.4 [redacted].	F 656	1. The care plans for residents # 171, 313, and 2 have been updated to reflect their specific needs/care. 2. All residents have the potential to be affected by this deficient practice. 3. Unit Managers and Nursing Supervisors have been reeducated on proper development of comprehensive care plans. 4. Audit will be done on 10 resident charts by the DON/designee weekly x 4, then	

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F 656	Continued From page 9 The surveyor observed the resident's bedside was cluttered with personal belongings, that included but were not limited to clothes, and food items. The windowsill was cluttered with clothing. The top of the resident's dresser was covered with items, including clothing and had a drawer partially open which was also filled with items. The resident's bedside table was filled with items, which included various containers and bottles. The resident stated they had other belongings that were in storage within the facility. Resident #171 verbalized no concerns. On 12/14/23 at 10:14 AM, the surveyor visited Resident #171 in their room. The surveyor observed fewer clothing items by the windowsill, but the resident's bedside remained disorganized and cluttered. The surveyor reviewed the hybrid medical record for Resident #171 which revealed the following: According to the Admission Record (an admission summary) (AR) the resident was admitted with diagnoses that included but were not limited to, *Ex Order 26. 4B1* [redacted]. The Annual Minimum Data Set (MDS), an assessment tool to facilitate care, dated Ex.Order 26.4(b)(1) indicated the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a [redacted] out of 15 which indicated that the resident *Ex Order 26. 4B1* [redacted]. A progress note, dated Ex.Order 26.4(b)(1) documented a	F 656	monthly x 3 to ensure a proper *Ex Order 26. 4B1* [redacted] is in place addressing the residents' specific care/needs. Audit findings will be shared with the QAPI committee monthly x 4 for review.	

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F 656	Continued From page 10 discussion with the social worker and Resident #171 in reference to the tidiness of their room, the benefits to their wellbeing, and reviewed the facility's policy for food storage. A review of the resident's care plans (CP), revealed there was no CP related to the resident's Ex.Order 26.4(b)(1) and cluttered room. On 12/14/23 at 10:44 AM, the surveyor interviewed CNA #1 who was assigned to care for Resident #171. CNA#1 stated Resident #171 was cooperative with staff, allowed housekeeping to clean their room, and the resident would usually clean up when encouraged by the staff. On 12/14/23 at 11:02 AM, the surveyor interviewed LPN #1 who was assigned to care for Resident #171. LPN #1 stated that the resident liked to keep personal belongings and other items at the bedside. LPN #1 further stated that the staff offered to clean and there were times the resident did not want staff to clean at that time so they would do it later. LPN #1 continued to explain if there were food items that should be thrown out, the resident would allow staff to throw it out. On 12/14/23 at 11:12 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager #1 (LPN/UM #1) about Resident #171. LPN/UM #1 stated the resident was protective of their belongings. LPN/UM #1 added that there have been attempts to encourage the resident to clean their room in the past and Resident #171 occasionally had gotten rid of things. LPN/UM #1 stated that the resident's Ex.Order 26.4(b)(1) and cluttered room was care planned.	F 656		

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F 656	Continued From page 11 The LPN/UM #1 reviewed Resident #171's CP with the surveyor and confirmed that there was no care plan related to the resident's hoarding and cluttered room. LPN/UM #1 stated that she was responsible for resident care plans as the unit manager. LPN/UM #1 continued to explain that she thought the resident's Ex.Order 26.4(b)(1) and their cluttered room had been care planned. On 12/15/23 at 11:36 AM, the surveyor informed the Director of Nursing (DON) about the above concerns. The DON acknowledged Resident #171's Ex.Order 26.4(b)(1) should have been included in the CP. On 12/19/23 at 9:50 AM, the surveyor informed the DON and the Licensed Nursing Home Administrator (LNHA) of the above concerns. No additional information was provided by the facility. 2.) On 12/12/23 at 11:39 AM, the surveyor observed resident #313 in the room eating lunch. The surveyor further observed that Resident # 313 was wearing *Ex Order 26. 4B1* . The surveyor reviewed Resident #313's hybrid medical records. The AR reflected that Resident #313 was admitted to the facility with medical diagnoses which included but not limited Ex Order 26. [redacted]. A review of the Quarterly MDS (Q/MDS), an assessment tool used to facilitate the	F 656		

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F 656	Continued From page 12	F 656		

management of care, dated 9/16/23 reflected that the resident had a BIM score of [redacted] out of 15 indicating that the resident had [redacted]. Further review of the Q/MDS "Section H - Appliances" under "H0300. [redacted]" which revealed that Resident #313 was [redacted] and "H0400. [redacted]" indicating that Resident #313 was frequently [redacted].

The surveyor reviewed Resident #313's comprehensive CP which revealed that there was no CP reflecting the resident's [redacted].

On 12/19/23 at 10:00 AM, the surveyor discussed the above concern to the facility's LNHA and DON. The DON stated that Resident #313 did not have a CP for [redacted]. The DON further stated that the CP should have included to address care for the resident's [redacted].

3. On 12/12/23 at 11:59 AM, the surveyor observed resident #2 seated in a recliner wheelchair inside the day/dining room. The surveyor further observed that Resident #2 had [redacted] to the [redacted].

The surveyor reviewed Resident #2's hybrid medical records. The AR reflected that Resident #2 was admitted to the facility with medical diagnoses which included but not limited to [redacted].

A review of the Annual MDS (A/MDS), an

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F 656	Continued From page 13 assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a BIMS score of [redacted] out of 15 indicating that the resident had *Ex Order 26. 4B1* [redacted]. Further review of the A/MDS "Section B - Hearing, Speech and Vision" under B1000. Vision which revealed that the resident had *Ex Order 26. 4B1*. The surveyor reviewed Resident #2's comprehensive CP which revealed that there were no CP addressing the resident's *Ex Order 26. 4B1* [redacted]. On 12/19/23 at 10:00 AM, the surveyor discussed the above concern to the facility's LNHA and DON. The DON stated that Resident #2 did not have a CP reflecting *Ex Order 26. 4B1*. The DON further stated that the CP should have included to address the care for resident's *Ex Order 26. 4B1*. A review of the facility's Policy and Procedure with a review date of January 2023 documented " It is the policy of Sinai Post Acute Nursing & Rehab Center that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner."	F 656		
F 657 SS=D	NJAC 8:39-11.2(e)(2)(f) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		1/16/24

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F 657	Continued From page 14 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise a resident's comprehensive care plan (CCP) for 1 of 35 residents reviewed, Resident #103. This deficient practice was identified by the following: On 12/12/23 at 11:40 AM, the surveyor observed Resident #103 in their room seated in their wheelchair. The resident was alert and verbally responsive.	F 657	1. The care plan for resident #103 was revised. 2. All residents on fluid restrictions have the potential to be affected by this deficient practice. 3. The RD will be reeducated and in serviced to ensure that fluid restriction care plans match current physician orders. 4. The Registered Dietitian/designee will review and audit weekly x 4 then monthly	

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F 657	Continued From page 15 The surveyor reviewed Resident #103's hybrid medical records. The Admission Record (AR) reflected that Resident #103 was admitted to the facility with medical diagnoses which included but was not limited to Ex Order 26. 4B1 [redacted]. According to Resident #103's Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated Ex.Order 26.4(b)(1) the Brief Interview for Mental Status (BIMS) was conducted and revealed that Resident #103's BIMS score was [redacted] out of 15 indicating the resident had an Ex Order 26. 4B1. The surveyor reviewed the residents CCP dated 11/2/23, which reflected a Ex Order 26. 4B1 [redacted] for Resident #103 titled, "[Resident's name] is at nutritional risk related to the need for Ex Order 26. 4B1 [redacted]. The [redacted] reflected that the Ex Order 26. 4B1 was current even though review of the Physician's Orders (PO) documented that the order had been discontinued on Ex.Order 26.4(b)(1) A review of the October 2023 Physician Orders (PO) revealed an order, Ex Order 26. 4B1 [redacted] restriction Nursing: Ex Order 26. 4B1 [redacted], with a start date of 2/13/23 and an end date of 10/18/23. On 12/18/23 at 11:26 AM, the surveyor conducted an interview with the Registered Dietitian, (RD), who stated they are responsible for updating the nutritional CP for residents. The RD further stated that she was not employed by the facility	F 657	x 3, 3 residents on fluid restrictions to ensure it matches the physician orders. Audit findings will be reported to the QAPI committee monthly x 4.	

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F 657	Continued From page 16 when the *Ex Order 26. 4B1* was discontinued for Resident #103. The current RD stated that the previous RD should have updated the CP to reflect the change in *Ex Order 26. 4B1* . On 12/18/23 at 11:45 AM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Policy and Procedure Manual: Care Plans, with a revised date of January 2023. Under the procedure section of the policy it states, 11. "Care Plans will be updated timely and necessary revisions will be made." On 12/19/23 at 9:55 AM, the surveyor met with the facility's Licensed Nursing Home Administrator and the DON regarding the above concern. The DON stated each department should revise the resident's care plans to reflect any changes.	F 657		
F 685 SS=D	NJAC 8:39-11.2(i) Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced	F 685		1/16/24

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F 685	Continued From page 17 by: Based on observation, interview and record review, it was determined that that facility failed to ensure that a follow up visit for an eye consultation was arranged for a resident with an *Ex Order 26. 4B1*. This deficient practice was identified for 1 of 1 resident reviewed for [redacted] Resident #2 and was evidenced by the following: On 12/12/23 at 11:59 AM, the surveyor observed Resident #2 seated in a recliner wheelchair inside the day/dining room. The surveyor further observed that Resident #2 had their *Ex Order 26. 4B1* shut proving some *Ex Order 26. 4B1* to the *Ex Order 26. 4B1*. The surveyor reviewed Resident #2's hybrid medical records. The admission record (AR) reflected that Resident #2 was admitted to the facility with medical diagnoses which included but were not limited to *Ex Order 26. 4B1* [redacted]. A review of the Annual Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status score of [redacted] out of 15 indicating that the resident had *Ex Order 26. 4B1* [redacted]. Further review of the A/MDS "Section B - Hearing, Speech and Vision" under B1000. Vision which revealed that the resident had *Ex Order 26. 4B1* [redacted]. A review of the form titled, "Resident Care Associates" dated [redacted] revealed that Resident #2 was seen and examined by the *Ex Order 26. 4B1* on [redacted] with the following impression: *Ex Order 26. 4B1*	F 685	1. Resident #2 has been seen by the [redacted]. 2. All residents being followed by the eye doctor have the potential to be affected by this deficient practice. 3. Unit managers and Nursing supervisors have been reeducated on ensuring timely follow up and necessary optometry visits for residents. Unit Managers will keep an annual calendar to ensure necessary follow-up visits are timely. 4. Audit will be done by the DON/designee monthly x 4 on 3 residents being followed by the eye doctor to ensure all follow up recommendations are being addressed and caried out. Audit findings will be shared with the QAPI committee monthly x 4 for review.	

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F 685	Continued From page 18 *Ex Order 26. 4B1* [redacted]." Further review of the form indicated that the medical protocol diagnosis requires a follow up visit after 6 months. The surveyor could not locate any documentation that a follow up visit from the Ex.Order 26.4(b)(1) was done after 6 months from the last visit on Ex.Order 26.4(b)(On 12/18/23 at 2:15 PM, the surveyor discussed to the facility's Licensed Nursing Home Administrator and Director of Nursing (DON) regarding the above concern. The DON stated that the resident was not seen by the Ex.Order doctor 6 months after the Ex.Order 26.4(b) visit. There was no additional information provided. NJAC 8:39-27.1 (a)	F 685		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a resident's medication times were adjusted to accommodate their *Ex Order 26. 4B1* [redacted] schedule for 1 of 1 resident, Resident #11 reviewed for Ex.Order 26. 4B1. This deficient practice was evidenced by the	F 698	1. The medication for resident #11 was scheduled to accommodate the resident's Ex.Order 26. 4B1 schedule. 2. All residents receiving dialysis have the potential to be affected by this deficient practice.	1/16/24

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F 698	Continued From page 19 following: On 12/12/23 at 11:58 AM, the surveyor observed that Resident #11 was not in their room. The resident was at [redacted] which was scheduled every [redacted]. A review of Resident #11's electronic medical record (EMR) revealed the following: According to the Admission Record (an admission summary), Resident #11 was admitted with diagnoses that included but were not limited to, [redacted] A Quarterly Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated [redacted] indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #11 scored [redacted] out of 15, which indicated that the resident had [redacted]. A physician's order dated [redacted] read: '[redacted] THREE TIMES WEEKLY ON ([redacted]) AT [redacted] center's name and address]. CHAIR TIME IS 10AM and p/u @ 9am. Tel number [redacted] center's phone number]. Transportation provided by [Transportation company's name]." A physician's order dated [redacted] read: [redacted] inhale orally every 8 hours for [redacted]". A review of the November 2023 electronic Medication Administration Record (eMAR) revealed that the resident was scheduled to receive the [redacted] medication as	F 698	3. Nurses have been reeducated and in-serviced to ensure that all medications for dialysis residents don't conflict with their dialysis schedule. 4. Audit will be done by the DON/designee weekly x 4 then monthly x 4 on 3 dialysis residents to ensure proper administration and timing of medication. Audit findings will be shared with the QAPI committee monthly x 4.	

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F 698	Continued From page 20 ordered above every day at 0600 [6 AM], 1400 [2 PM], and 2200 [10 PM]. The entries for 1400 on Ex.Order 26.4(b)(1) were signed by the nurses with "[redacted]", which indicated "Other/See nurses notes" and that the medication was not administered. The entry for 1400 on [redacted] was signed by the nurse with "[redacted]" which indicated the resident was "[redacted]" and the medication was not administered to the resident. A review of the December 2023 eMAR revealed that the resident was scheduled to receive [redacted] medication as ordered above every day at 0600, 1400, and 2200. The entries for 1400 on Ex.Order 26.4(b)(1) [redacted] were signed by the nurses with "[redacted]", which indicated "Other/See nurses notes" and that the medication was not administered. A review of the nurses' progress notes in the Electronic Medical Record (EMR) revealed that the medication was not administered on the entries identified above as the resident was out to dialysis during the medication administration time. On 12/22/23 at 10:05 AM, the surveyor interviewed the Director of Nursing (DON) who stated it was the facility's protocol for medications to be scheduled to accommodate for when residents went to [redacted]. The surveyor reviewed the November 2023 and December 2023 eMAR for Resident #11 with the DON. The DON acknowledged the medication should have been scheduled to accommodate the resident's [redacted] schedule. On 12/22/23 at 12:05 PM, the survey team met with the Licensed Nursing Home Administrator,	F 698		

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F 698	Continued From page 21 the DON, and regional staff. There was no additional information provided by the facility. A review of the facility's policy titled "Dialysis Policy", last revised in June 2023, under Procedure it read: " ...2. The admitting nurse must ensure that medications are timed with the dialysis days/ schedule of the resident ..."	F 698		
F 711 SS=D	NJAC 8:39-27.1(a) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents: a) wrote physician progress notes (PPN) at least every 30 days, b) wrote physician progress notes (PPN) at least every 60 days with	F 711	1. Physician notes for residents #'s 176, 141, 154, 11, 174, 255, 103, 22, and 104 have been uploaded to their charts. 2. All residents have the potential to be affected by this deficient practice.	1/16/24

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F 711	Continued From page 22 alternating Nurse Practitioner (NP) visits, and c) accurately date physician progress notes (PPN). This deficient practice was observed for 9 of 35 residents, Resident #176, 141, 154, 11, 174, 255, 103, 22, and 104 reviewed. This deficient practice was evidenced by the following: 1. On 12/12/23 at 12:08 PM, the surveyor observed Resident #176 lying in their bed, awake, Ex.Order 26.4(b)(1) [redacted]. The resident verbalized no concerns. The surveyor reviewed Resident #176's hybrid (paper and electronic) medical records. According to the Admission Record (an admission summary) (AR), Resident #176 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted]. A review of the PPN revealed that Resident #176's primary physician last documented that he had visited and examined the resident on Ex.Order 26.4(b)(1 [redacted]. There was no documentation of any PPN between August 2023 and November 2023 to indicate a face-to-face visit and examination of Resident #176. On 12/19/23 at 9:50 AM, the surveyor informed the Director of Nursing and the Licensed Nursing Home Administrator of the above concerns. No further information was provided by the facility.	F 711	3. All attending physicians have been reeducated on the regulation of timely physician visits and documentation. 4. Audit will be done by the DON/designee on 10 resident charts monthly x 4 to ensure physician visits and documentation are done in a timely manner. Audit results will be shared with the QAPI committee monthly x 4 months.	

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F 711	Continued From page 23 2. On 12/12/23 at 12:12 PM, the surveyor observed Resident #141 lying in their bed with the head of the bed elevated. Resident #141 was awake, Ex.Order 26.4(b)(1) their name. The surveyor reviewed Resident #141's hybrid medical records. According to the AR, Resident #141 was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted]. A review of the PPN revealed that Resident #141's primary physician last documented that he had visited and examined the resident on Ex.Order 26.4(b)(1). There was no further documentation of PPNs between December 2022 to November 2023 to indicate a face-to-face visit and examination of Resident #141. On 12/19/23 at 9:50 AM, the surveyor informed the Director of Nursing and the Licensed Nursing Home Administrator of the above concerns. The DON stated the physician was expected to see their residents and write their notes at least every month. No further information was provided by the facility. 3. On 12/12/23 at 12:25 PM, the surveyor observed Resident #154 lying in their bed the head of the bed elevated. The resident was awake and Ex.Order 26.4(b)(1) The surveyor reviewed Resident #154's hybrid medical records.	F 711		

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F 711	Continued From page 24 According to the AR, Resident #154 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted]. A review of the PPN revealed there were no PPNs found for Resident #154 in February 2023, March 2023, April 2023, May 2023, and June 2023 to indicate a face-to-face visit and examination of Resident #154 at least every 30 days. On 12/19/23 at 9:50 AM, the surveyor informed the Director of Nursing and the Licensed Nursing Home Administrator of the above concerns. The DON stated the physician was expected to see their residents and write their notes at least every month. No further information was provided by the facility. 4. On 12/12/23 at 11:58 AM, the surveyor observed that Resident #11 was not in their room. The resident was at Ex Order 26. 4B1 which was scheduled every Ex Order 26. 4B1 [redacted]. The surveyor reviewed the hybrid medical records of Resident #11. According to the Admission Record, Resident #11 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted]. A review of the PPN revealed that Resident #11's primary physician last documented that he had visited and examined the resident on Ex.Order 26.4(b)[redacted]. There was no documentation in October 2023	F 711		

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F 711	Continued From page 25	F 711		

and November 2023 to indicate a face-to-face visit and examination of Resident #11.

On 12/22/23 at 9:11 AM, the surveyor informed the DON and LNHA of the above concerns.

On 12/22/23 at 9:35 AM, the surveyor informed the DON of the above concerns. The DON stated the resident's primary physician was backed up with documenting his notes.

5. On 12/14/23 at 10:27 AM, the surveyor observed Resident #174 seated in a chair at their bedside. The resident was alert, pleasant, and Ex.Order 26.4(b)(1) their name.

The surveyor reviewed Resident #174's hybrid medical records.

According to the AR, Resident #174 was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted].

A review of the PPN revealed that Resident #174's primary physician last documented that he had visited and examined the resident on [redacted]. An NP working with the primary physician documented a practitioner progress note at least monthly when visiting and examining the resident between July 2023 to November 2023. There was no progress note documented at least every 60 days by the primary physician between July 2023 to November 2023 to indicate a face-to-face visit and examination of Resident

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F 711	Continued From page 26 #174. On 12/22/23 at 9:11 AM, the surveyor informed the DON and LNHA of the above concerns. On 12/22/23 at 11:55 AM, the survey team met with the Licensed Nursing Home Administrator and the Director of Nursing. No further information was provided by the facility. 6. On 12/13/23 at 11:22 AM, the surveyor observed Resident #255 in bed with eyes closed. The surveyor reviewed Resident #255's hybrid medical records. According to the AR, Resident #255 was admitted to the facility with diagnoses that included but were not limited to, *Ex Order 26. 4B1* [redacted] A review of Resident #255's documented PPNs revealed that primary physician had numerous "LATE ENTRY" (Any documentation that is recorded in the medical record beyond 24-48 hours of the encounter) documentations which indicates the notes were not written on the effective date (date of service): 1. PPN with an effective date of [redacted], but with a created date of [redacted]. 2. PPN with an effective date of [redacted], but with a created date of [redacted]. 3. PPN with an effective date of [redacted], but with a created date of [redacted]	F 711		

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F 711	Continued From page 27 4. PPN with an effective date of [redacted], but with a created date of [redacted]. 5. PPN with an effective date of [redacted] but with a created date of [redacted]. 7. On 12/12/23 at 11:40 AM, the surveyor observed Resident #103 sitting in a wheelchair, awake [redacted]. The resident verbalized no concerns. The surveyor reviewed Resident #103's hybrid medical records. According to the AR, Resident #103 was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted]. A review of Resident #103's documented PPNs revealed that the primary physician had numerous "LATE ENTRY" (Any documentation that is recorded in the medical record beyond 24-48 hours of the encounter is classified as a Late Entry.) documentations which indicates the notes were not written on the effective date (date of service): 1. PPN with an effective date of [redacted] but with a created date of [redacted] 2. PPN with an effective date of [redacted] but with a created date of [redacted] 3. PPN with an effective date of [redacted], but with a created date of [redacted]. 4. PPN with an effective date of [redacted] but with a created date of [redacted].	F 711		

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F 711	Continued From page 28 5. PPN with an effective date of [Ex.Order 26.4(b)(1)], but with a created date of [Ex.Order 26.4(b)(1)]. 6. PPN with an effective date of [Ex.Order 26.4(b)(1)] but with a created date of [Ex.Order 26.4(b)(1)]. 7. PPN with an effective date of [Ex.Order 26.4(b)(1)] but with a created date of [Ex.Order 26.4(b)(1)]. On 12/18/23 at 11:13 AM, the surveyors conducted a phone interview with the Medical Director (MD). The MD stated that he comes into the facility to see residents, take notes on paper, and document in his office. Following completion of the notes, the MD informed the surveyor that he signs and uploads the notes to the electronic record. The MD further stated, "I did forget to upload notes for some notes, it is my fault. I have to write, sign, and upload my notes in a timelier fashion." On 12/18/23 at 11:19 AM, the DON provided the surveyor with facility policy titled, Physician Visits, with a revised date of January 2023. Under the procedure of the policy it states, "The physician visits includes: reviewing the resident's total program of care, including medications and treatments, at each visit and writing, signing, and dating progress notes at each visit." The DON stated that all the physicians are expected to write, sign and date their notes at the time of visit. 8. On 12/14/23 at 10:20 A.M., the surveyor observed Resident #22 sitting in the wheelchair inside the activity room. A review of the AR for Resident #22 reflected that the resident was admitted to the facility with	F 711		

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F 711	Continued From page 29 diagnoses that included but were not limited to [redacted]. The resident's most recent Quarterly MDS, dated [redacted] reflected that Resident #22 had a BIMS score of [redacted] out of 15, which indicated that the resident had [redacted]. Review of the PPNs for December 2022, January 2023, February 2023, March 2023, April 2023, May 2023, June 2023, July 2023, August 2023, September 2023, October 2023, and November 2023 revealed that there were no PPNs written for Resident #22. On 12/18/23 at 11:13 AM, the surveyors interviewed the physician via the phone. The physician informed the surveyor that he usually comes into the building three times a month or once a month if he needs to check the resident, review the lab works, if any, and sign the Physician's Order Sheet (POS). The physician added that he usually documents in his office after seeing the resident but forgot to upload it in the computerized medical record. On 12/19/23 at 9:53 AM, the surveyors met with the LNHA and DON. The DON stated that the physician should document in the progress notes every month. A review of the facility policy for "Physician Visits" dated as revised January 2023 provided by the DON revealed under Procedure, "The physician visits include: Reviewing the resident's total program of care, including medications and treatments, at each visit and writing, signing, and dating progress notes at each visit."	F 711		

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9. On 12/18/2023 at 12:15 PM, the surveyor interviewed Resident #104 in their room. The resident stated they could not recall the last time they had seen a physician.

The surveyor reviewed the hybrid medical records (paper and electronic) for Resident #104.

A review of the resident's Admission Record (A one-page summary of important information about the resident.) revealed diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted].

A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated Ex.Order 26.4(b)(1), indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating that the resident had Ex Order 26. 4B1.

A review of the Order Summary Reports for the months of July, August and September that were on the resident's paper chart revealed that the nurse practitioner (NP) had signed the physician's orders for three (3) consecutive months. The primary physician had signed the Order Summary Reports for the months of October and November.

A review of the Physician's Progress Notes (PPN) in the electronic medical record revealed that the latest entry was dated Ex.Order 26.4(b)(1). There were no further PPN entries.

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F 711	Continued From page 31 On 12/19/2023 at 9:50 AM, the survey team met with the Director of Nursing (DON). The DON stated that the physicians were expected to see the resident and write a progress note every month. On 12/19/23 at 11:19 AM, the surveyor interviewed the DON who acknowledged that the last PPN entry for Resident #104 was dated Ex.Order 26.4(b)(1). The DON also acknowledged that the physician orders were signed by the NP for July, August and September. The DON stated that the primary physician was supposed to alternate monthly signing of the Order Summary Reports with the NP. A review of the facility policy for "Physician Orders" dated as revised January 2023 provided by the DON revealed that "It is the policy of the facility to secure physician orders for care and services for residents as required by state and federal law. All orders will be dated and signed by the physician or nurse practitioner according to state and federal guidelines." A review of the facility policy for "Physician Visits" dated as revised January provided by the DON revealed that "It is the policy of the facility to ensure that the medical care of each resident is supervised by a physician." In addition, the policy reflected under procedure "The resident is to be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. After the initial physician visit	F 711		

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F 711	Continued From page 32 the Nurse Practitioner of Physician Assistant may make every other required visit."	F 711		
F 800 SS=D	NJAC 8:39-23.2(b) Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, the facility failed to ensure that foodservice equipment was stored properly when not in use. This deficient practice was observed and evidenced by the following: On 12/12/23 at 9:23 AM, during the initial tour of the kitchen in the presence of the Food Service Director (FSD), the surveyor observed the following: On Chef prep table #3, the deli slicer was not in use and the slicing blade was not in locked position. When the FSD attempted to lock the slicing blade, the blade was not able to completely close, leaving the blade exposed. The FSD stated that the slicing blade needed to be in a locked position and in a nonexposed position when not in use for the safety of the dietary staff.	F 800	1. The meat slicer was repaired and is able to be put into an off position where the blade will not be exposed. 2. All dietary personnel have the potential to be affected by this deficient practice. 3. All dietary personnel were reeducated on how to properly shut and off the slicer when not in use. 4. The Food Director/designee will conduct an audit weekly x 4 then monthly x 3 to ensure the slicer is in proper working condition and is being stored properly. Audit findings will be shared with the QAPI committee monthly x 4.	1/16/24

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F 800	Continued From page 33 On 12/19/23 at 9:57 AM, the surveyor team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to review areas of concerns in the kitchen, that included the slicer. The surveyor also requested policies on kitchen equipment and safety. On 12/19/23 at 10:15 AM, the FSD provided the surveyor with a facility policy titled, Dining Service, Deli Slicer, with a revised date of 10/1/2023. Under operation of Equipment it states, "reset gauge to "off" position". Surveyor asked the FSD what does reset gauge specifically mean? FSD stated, reset gauge to off position, means to turn the slicing blade into to the off position, so it is no longer exposed and in a locked position. On 12/22/23 at 11:30 AM, the survey team met with the LNHA and DON to discuss any responses for the highlighted issue in the kitchen. No further information was provided regarding the deli slicer issue.	F 800		
F 812 SS=D	NJAC 17.4(a)(2) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		1/16/24

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F 812	Continued From page 34 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store and discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 12/12/23 at 09:23 AM, the surveyor in the presence of the Food Service Director (FSD) observed the following during the kitchen tour: 1. In the food preparation area, two dietary aides with hair not fully restrained under their hairnet. 2. On the three shelf storage unit, one 32 ounce bottle of Gravy Master Grilling, Seasoning and Browning Sauce missing the top closing cap which provides an airtight seal on the bottle preventing contamination and freshness. The surveyor observed the bottle with plastic wrap around the top opening. 3. In walk in freezer #2, multiple boxes of ice cream were stocked to top of ceiling, not utilizing 18 inches below ceiling storage regulation.	F 812	1. The spice bottle was discarded. The employees noted with some hair not restrained under their hairnet were immediately reeducated. The boxes in the freezer were repositioned to allow for 18 inches below the ceiling. 2. All residents have the potential to be affected by this deficient practice. 3. All dietary staff were reeducated and in-serviced regarding proper hairnet covering, proper seal and storage of spice bottles, and proper storage within the fridge/freezer to allow for 18 inches below the ceiling. 4. Audit will be done by the Food Service Director/designee weekly x 4 then monthly x 3 to ensure all dietary employees are covering their hair and beards properly, all spice bottles are sealed properly and that the storage within the freezer is below 18 inches. Audit findings will be reported to the QAPI committee monthly x 4 for review.	

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4. In walk-in refrigerator #1, multiple boxes of creamer were observed stocked to ceiling, not utilizing 18 inches below ceiling regulation.

During the surveyor interview with the FSD, he stated that all dietary staff need to have their hair fully restrained under the hairnets. He added that the bottle of Gravy master should have been discarded when the top closing cap was misplaced and that the plastic wrap is not sufficient for maintaining the freshness of the product. The FSD further added that nothing stored in the walk-in freezer and refrigerator should be stored within 18 inches from the ceiling.

On 18/18/23 at 9:57 AM, the FSD provided the surveyor with a copies of facility policies for Dining Service - Personal Hygiene and Food Storage. A review of the facility policy titled, "Dining Services - Personal Hygiene", with a reviewed date of 10/1/23 revealed under the procedure, 3. "If hair is long and not covered properly with a cap, a hairnet must be worn." A review of the facility policy titled, "Food Storage" revealed under the policy section, Food items will be stored, thawed, and prepared in accordance with good sanitary practice. The policy further stated under storage, "All food items shall be storage 6 inches from the floor and 18 inches from the ceiling." "Any open products shall be place in seamless plastic or glass containers with tight-fitting lids or Ziploc bags."

On 12/22/23 at 11:30 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of nursing (DON). No further information was provided.

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F 812	Continued From page 36	F 812		
F 880 SS=D	NJAC 8:39-17.2(g) 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	F 880		1/16/24

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F 880	Continued From page 37 reported; (iii) Standard and transmission-based precautions 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 review of pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices for performing hand hygiene to decrease the possibility of spreading infection. This deficient practice was observed	F 880	1. The nurse identified was immediately reeducated on proper hand washing protocols. 2. All residents have the potential to be affected by this deficient practice in regard	

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F 880	Continued From page 38 during Ex Order 26. 4B1 observation with 1 of 1 nursing staff on 1 of 5 units and was evidenced by the following: On 12/19/23 at 10:17 AM, the surveyor observed Licensed Practical Nurse #1 (LPN#1) perform Ex Order 26. 4B1 for Resident #154. On 12/19/23 at 10:29 AM, LPN #1 was observed preparing to wash her hands at the sink in Resident #154's room after preparing the supplies for the Ex Order 26. 4B1 at the bedside table. LPN #1 turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands for 15 seconds outside the running water prior to rinsing, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. On 12/19/23 at 10:32 AM, LPN #1 removed and discarded her gloves after removing the resident's old Ex Order 26. 4B1. LPN #1 went to wash her hands at the sink in the room, turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands 15 seconds outside the running water prior to rinsing, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet. On 12/19/23 at 10:36 AM, LPN #1 after cleansing the Ex Order 26. 4B1, removed her gloves and discarded them in the garbage to wash her hands at the sink. LPN #1 turned on the faucet, wet her hands with water from the sink, applied soap, lathered her hands 18 seconds outside the running water prior to rinsing, dried her hands with a paper towel from the dispenser on the wall and used another paper towel to turn off the faucet.	F 880	to hand hygiene/Infection prevention & control. 3. All nursing staff have been reeducated on proper hand hygiene. 4. Audit will be done by the Infection Preventionist/designee on 10 nursing employees weekly x 4, then monthly x 3 to ensure proper hand hygiene competency. Audit findings will be shared with the QAPI committee monthly x 4.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315236	A. BUILDING _____ B. WING _____	C 12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI POST ACUTE NURSING AND REHAB CENTER	**65 JAY STREET NEWARK, NJ 07103**

(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 39 On 11/30/23 at 11:15 AM, after *Ex Order 26. 4B1* was completed the surveyor interviewed LPN #1 about handwashing procedure. LPN#1 stated hands should be washed at least 15-20 seconds and was able to explain to the surveyor the correct steps of handwashing. On 12/19/23 at 10:52 AM, the surveyor interviewed the Infection Preventionist Registered Nurse who stated handwashing should be performed for at least 20 seconds and confirmed that it was the facility's policy. On 12/19/23 at 12:45 PM, the surveyor informed the Director of Nursing (DON) of the handwashing concerns during the observed *Ex Order 26. 4B1* . The DON stated handwashing was expected to be performed for at least 20 seconds. A review of the facility's policy titled "Hand Hygiene" with a review date of August 2023, under Procedure it read: " ...Rub hands together vigorously to make lather, covering all surfaces of the hands and fingers. Continue rubbing hands for at least 20 seconds ..." On 12/19/23 at 2:10 PM, the survey team met with the DON and Licensed Nursing Home Administrator. No additional information was provided by the facility. N.J.A.C. 8:39-19.4	F 880		

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
	060713	A. BUILDING: _____ B. WING _____	C 12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI POST ACUTE NURSING AND REHAB CE	65 JAY STREET NEWARK, NJ 07103

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 observation, interview, and 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. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing	S 560	1. There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements during the 7:00am -3:00pm shift on the dates 11/26/23, 11/27/23, 11/28/23, 11/29/23, 11/30/23, 12/1/23, 12/2/23, 12/3/23, 12/4/23, 12/5/23, 12/6/23, 12/7/23, 12/8/23, and 12/9/23. 2. All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios. 3. The following measures have been put into place to prevent the deficient practice from recurring: Advertisement / Job	1/16/24

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

Electronically Signed | 01/04/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060713	A. BUILDING: _____ B. WING _____	C 12/22/2023

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S 560	Continued From page 1 requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to	S 560	postings for CNA's have been posted on social media websites. Incentives are offered to CNA's to work extra shifts. Incentives are offered for referring a nursing employee. The facility has partnered with staffing agencies. The facility has partnered with a CNA school in an effort to be able to recruit the students once they have completed their certification. 4. The Administrator/designee will review the staffing schedule weekly x 4 then monthly x 3 to monitor the staffing ratio on the 7am - 3pm shift. The findings will be reported to the QAPI committee monthly x 3 months.	

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 2 affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 11/26/23 and ending 12/09/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements for 14 of 14 day shifts. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/26/23 had 18 CNAs for 341 residents on the day shift, required at least 43 CNAs. -11/27/23 had 33 CNAs for 336 residents on the day shift, required at least 42 CNAs. -11/28/23 had 39 CNAs for 335 residents on the day shift, required at least 42 CNAs. -11/29/23 had 39 CNAs for 335 residents on the day shift, required at least 42 CNAs. -11/30/23 had 38 CNAs for 335 residents on the day shift, required at least 42 CNAs. -12/01/23 had 41 CNAs for 335 residents on the day shift, required at least 42 CNAs. -12/02/23 had 36 CNAs for 335 residents on the day shift, required at least 42 CNAs. -12/03/23 had 22 CNAs for 335 residents on the day shift, required at least 42 CNAs. -12/04/23 had 33 CNAs for 333 residents on the day shift, required at least 42 CNAs. -12/05/23 had 35 CNAs for 333 residents on the day shift, required at least 42 CNAs. -12/06/23 had 39 CNAs for 333 residents on the day shift, required at least 42 CNAs. -12/07/23 had 36 CNAs for 333 residents on the	S 560		

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S 560	Continued From page 3 day shift, required at least 42 CNAs. -12/08/23 had 35 CNAs for 333 residents on the day shift, required at least 42 CNAs. -12/09/23 had 29 CNAs for 345 residents on the day shift, required at least 43 CNAs. On 12/14/23 at 10:00 AM , the surveyor discussed the lack of required staff with the Director of Nursing and Licensed Nursing Home Administrator who did not provide any further information.	S 560		
S1030	8:39-11.2(c) Mandatory Resident Assessment and Care Plans (c) Each resident shall be examined by a physician or advanced practice nurse within five days before, or 48 hours after, admission. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to have residents evaluated, history and physicals (H&P) performed within 48 hrs. of admission by the physician in accordance with New Jersey State requirements. This deficient practice was noted for 3 of 3 residents reviewed for new admission requirements, Resident #346, #340 and #343. This deficient practice was evidenced by the following: 1. On 12/18/23 at 12:38 PM, the surveyor reviewed the closed hybrid medical records for Resident #346, who was documented as	S1030	1. Residents #'s 346, 343, and 340, suffered no ill effects by this deficient practice. 2. All new admissions have the potential to be affected by this deficient practice. 3. All the attending physicians have been reeducated on the regulation of H&P's needing to be completed by the physician within 48 hours of admission. 4. 10 new admissions will be audited by the DON/designee weekly x 4, then monthly x 3 to ensure a H&P has been completed timely. Audit findings will be	1/16/24

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S1030	Continued From page 4 admitted to the facility on [redacted] Review of the Admission Record (a one-page summary of important information about the patient) (AR) reflected Resident #346 was admitted with diagnosis that included but were not limited to [redacted]. Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] documented that Resident #346 was admitted to the facility on [redacted] from a "[redacted] General Hospital." Review of the [redacted] Progress Note Text documented by nursing that Resident #346 was admitted to the facility, "Resident is [redacted]" Review of Facility Progress Notes and the paper chart from [redacted] (Resident #346 discharge date) did not present any [redacted] performed by the Physician. There was no documentation noted from the Physician showing any [redacted] performed by the physician during the time that Resident #346 was in the facility. Review of the facility policy and procedure "Physician Visits: Initial Medical Assessment and Routine Follow-up Visits" explains under "Admission General and Restoration, within a time frame 1. Initiate the medical assessment, including a history and physical examination (H&P), within a time frame appropriate to the resident/patient's condition not to exceed 24 hours before admission or 48 hours after	S1030	reported to the QAPI committee monthly x 4 for review.	

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S1030	Continued From page 5 admission (according to State regulations)." On 12/19/23 at 10:11 AM, the surveyor discussed the lacking Physician [Ex Order 26] for Resident #346 with the Director of Nursing (DON). The DON revealed that there was no [Ex Order 26] performed by the Physician during the Ex.Order 26.4(b)(1) resident stay at the facility. The DON did not provide any further information related to this issue. 2. On 12/18/23 at 12:38 PM, the surveyor reviewed the closed hybrid medical records for Resident #340, who was documented as admitted to the facility on [Ex Order 26. 4B1] and was discharged to the community on [Ex Order 26. 4B1]. Review of the AR reflected that Resident #340 was admitted with diagnosis that included but were not limited to *Ex Order 26. 4B1* [redacted] Review of the Admission MDS, an assessment tool used to facilitate the management of care, dated [Ex.Order 26.4(b)(1)] documented that Resident #340 was admitted to the facility on [Ex Order 26. 4B1] from a "[Ex Order 26. 4B1] General Hospital." Review of the [Ex.Order 26.4(b)(1)] Admission Summary (AS) note text documented by nursing that Resident #340 was admitted to the facility from the hospital at [Ex Order 26. 4B1]. Further review of the AS note documented "MD (Medical Doctor) notified of admission medication reviewed". A review of Resident #340's hybrid medical	S1030		

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S1030	Continued From page 6 records from admission date of Ex Order 26. 4B1 (Resident #340's discharge date) did not reveal any documentation of the resident's Ex Order 26. 4B1 assessment that was performed by the Physician during the time when Resident #340 was in the facility. Review of the facility policy and procedure "Physician Visits: Initial Medical Assessment and Routine Follow-up Visits" explains under "Admission General and Restoration, within a time frame 1. Initiate the medical assessment, including a history and physical examination (H&P), within a time frame appropriate to the resident/patient's condition not to exceed 24 hours before admission or 48 hours after admission (according to State regulations)." On 12/19/23 at 10:11 AM, the surveyor discussed the lacking Physician Ex Order 26 for Resident #346 to the DON. The DON stated that there was no Ex Order 26 assessment performed by the Physician during the resident's stay from Ex Order 26. 4B1. The DON did not provide any further information related to this issue. On 12/18/23 at 1:05 PM, the surveyor reviewed the electronic medical records for Resident #343, who was documented as admitted to the facility on Ex Order 26. 4B1. Review of the AR reflected Resident #343 was admitted with diagnosis that included but were not limited to Ex Order 26. 4B1.	S1030		

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S1030	Continued From page 7 Review of the Admission MDS, an assessment tool used to facilitate the management of care, dated Ex.Order 26.4(b)(1) documented that Resident #343 was admitted to the facility on Ex Order 26. 4B1 from a "Ex Order 26. 4B1 General Hospital." Review of the Ex Order 26. 4B1 Progress Note Text documented by nursing that Resident #343 was admitted to the facility, "Resident Ex.Order 26.4(b)(1) . Ex Order 26. 4B1 verified the medication order." Review of Facility Progress Notes in the electronic medical record from Ex.Order 26.4(b)(1) did not present any Ex Order 26. 4B1 performed by the Physician. There was no documentation noted from the Physician showing any Ex Order 26 performed by the physician during the time that Resident #343 was in the facility. Review of the facility policy and procedure "Physician Visits: Initial Medical Assessment and Routine Follow-up Visits" explains under "Admission General and Restoration, within a time frame 1. Initiate the medical assessment, including a history and physical examination (H&P), within a time frame appropriate to the resident/patient's condition not to exceed 24 hours before admission or 48 hours after admission (according to State regulations)." On 12/18/23 at 2:25 PM, the DON provided a Physician/Practitioner Progress Note that reflected a created date of 12/18/23 at 2:08 PM by the resident's physician of record. The Progress Note also reflected "Late Entry". On 12/19/23 at 9:56 AM, the surveyor discussed the lacking Physician Ex Order 26 for Resident #343 with	S1030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1030	Continued From page 8 the DON. The DON stated that the physician should see and write a note for a resident that was admitted and in the building within 24 hours. Additionally, the DON stated that the Physician/Practitioner Progress Note with a created date of 12/18/23 and an effective date of Ex.Order 26.4(b)(1) written on 12/18/23 and was late. The DON did not provide any further information related to this issue. NJAC 8:39-11.1, 11.2(e)(1)	S1030		

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
315236 Y1	A. Building B. Wing Y2	2/23/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI POST ACUTE NURSING AND REHAB CENTER	65 JAY STREET NEWARK, NJ 07103

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 F0584	Correction	ID Prefix F0641	Correction	ID Prefix F0656	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	02/16/2024	LSC	01/16/2024	LSC	02/16/2024
ID Prefix F0657	Correction	ID Prefix F0685	Correction	ID Prefix F0698	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.25(a)(1)(2)	Completed	Reg. # 483.25(l)	Completed
LSC	01/16/2024	LSC	01/16/2024	LSC	01/16/2024
ID Prefix F0711	Correction	ID Prefix F0800	Correction	ID Prefix F0812	Correction
Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.60	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	01/16/2024	LSC	01/16/2024	LSC	01/16/2024
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/16/2024	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?
12/22/2023	☐ YES ☐ NO

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
315236 (Y1)	A. Building B. Wing (Y2)	2/23/2024 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI POST ACUTE NURSING AND REHAB CENTER	65 JAY STREET NEWARK, NJ 07103

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 01/16/2024	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
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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 12/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060713 Y1	A. Building B. Wing Y2	2/23/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI POST ACUTE NURSING AND REHAB CENTER	65 JAY STREET NEWARK, NJ 07103

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 01/16/2024	ID Prefix S1030 Reg. # 8:39-11.2(c) LSC	Correction Completed 01/16/2024	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

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 12/22/2023	☐ 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
	315236	A. BUILDING **01** B. WING _____	**12/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI POST ACUTE NURSING AND REHAB CENTER	**65 JAY STREET** **NEWARK, NJ 07103**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/12/2023, 12/13/2023 and 12/14/2023 and Sinai Post Acute N&R 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 Sinai Post Acute N&R CTR.is a 7-story building that was built in 80's, It is composed of Type I (fire resistant) construction. The facility is divided into 24- smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director.	K 000		
K 222 SS=E	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 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.	K 222		2/20/24

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

Electronically Signed | 01/08/2024

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
	315236	A. BUILDING **01** B. WING _____	**12/22/2023**

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K 222	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 review of facility provided documentation on 12/12/2023, it was determined that the facility failed to provide 1 of 8 designated exit discharge (illuminated exit signs above door) doors and 1 designated exit access (illuminated exit signs above doors) doors with-in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a seven-story (7) building with eight (8) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 10:00 AM on 12/12/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. Along the tour at approximately 1:48 PM, the	K 222	1. The thumb turn lock will be removed from both sets of double doors by the main entrance. A sign stating “Push in case of an emergency” will be posted by the doors. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department has been reeducated on the regulation regarding egress doors. 4. The maintenance director/designee will audit monthly x 4 the 2 sets of double doors by the main entrance to ensure proper signage and no thumb turn lock is present. Audit findings will be shared with the QAPI committee monthly x 4.	

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K 222	Continued From page 3 surveyor observed the main entrance one (1) set of (external) exit discharge doors and one (1) set of (internal set of doors) revealed thumb turn lock on the egress side of the two sets of doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. A review of an emergency evacuation diagram posted in the corridor identify these two (2) sets of double doors are the primary doors to reach an exit discharge in the event of an emergency. Both sets of double automatic doors also failed to identify with a sign to open doors that states "Push in case of an Emergency." The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 225 SS=D	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 observations and review of facility provided documentation on 12/12/2023, it was determined that the facility failed to provide exit	K 225	1. The items stored in the 7th floor center stairwell will be removed.	2/20/24

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K 225	Continued From page 4 stairwells free of storage and combustible material in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.3, 19.2.2.4 and 7.2. The evidence includes the following, On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a seven-story (7) building with four (4) exit stairwells (South, Center, West and North) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 10:00 AM on 12/12/2023 in the presence of the facility's RPOD and MD a tour of the facility was conducted. Alone the tour at approximately 10:42 AM, an inspection inside the 7th. floor Center stairwell was performed. The surveyor observed stored on the top landing Combustible boxes, Mechanical and Communications equipment. The findings were verified by the RPOD and MD at the time of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39 31.2 (e)	K 225	2. Anyone needing to use the stairwell in case of an emergency has the potential to be affected by this deficient practice. 3. Maintenance staff were reeducated on the regulation of keeping emergency stairwells clear. 4. Audit will be done by the maintenance director/designee monthly x 4 to ensure emergency stairwells are free of storage. Audit findings will be shared with the QAPI committee monthly x 4.	

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K 291	Continued From page 5	K 291		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/2023 and 12/14/2023 in the presence of facility management, it was determined that the facility failed to: Provide a functioning battery backup emergency lighting in 1 of 3 rooms the emergency generator's transfer three (3) switch locations, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 12/12/2023 during the survey entrance at approximately 09:30 AM, a request was made to the Administrator, Regional Plant Operations Director and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested, does the facility have an emergency generator. The MD told the surveyor, yes we have an Diesel Emergency Generator. On 12/14/2023 (day three of survey) at approximately 11:27 AM, an inspection of the ASCO series 306 emergency generator transfer switch was performed. The surveyor observed no evidence of a battery back-up. The surveyor made a request to the MD do you have a battery back-up emergency light for the generator	K 291	1. A battery backup emergency light for the generator transfer switch will be installed. 2. All residents have the potential to be affected by this deficient practice. 3. The Maintenance team was educated on the importance of having a battery backup emergency light for the generator. 4. The Maintenance Director/designee will conduct an audit monthly x 4 to ensure the battery backup light by the generator is working properly. Audit findings will be shared with the QAPI committee monthly x 4.	2/20/24

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K 291	Continued From page 6 transfer switch. The MD told the surveyor, no. This finding was verified by the facility's Maintenance Director and Regional Plant Operations Director during the observation. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 12/12/2023, 12/13/2023 and 12/14/2023 in the presence of facility management, it was determined that the facility failed to: 1) To provide one (1) illuminated exit sign to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by	K 293	1. An illuminated exit sign will be installed in the first-floor corridor while facing elevators #1 and #2 to clearly identify the exit access route. 2. Anyone in the facility has the potential to be affected by this deficient practice. 3. The maintenance department was reeducated on the regulation of having properly illuminated exit signs identifying exit access routes.	2/20/24

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K 293	Continued From page 7 approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and	K 293	4. The maintenance director/designee will conduct an audit monthly x 4 months on 10 exit doors to ensure they have properly illuminated exit signs. Audit findings will be shared with the QAPI committee monthly x 4 months for review.	

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K 293	Continued From page 8 Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a seven-story building with eight (8) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023 and 12/14/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. During the three (3) day tour, on 12/14/2023 (day three) at approximately 11:34 AM the surveyor observed on the first floor corridor while standing next to elevators #3 and #4 and looking towards elevators #1 and #2 the facility failed to have one (1) illuminated exit sign to clearly identify the exit access route to reach an exit. A review of an emergency evacuation diagram post on the wall in the corridor identify the route as the primary and / or secondary exit access route to reach an exit. The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		

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K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 12/12/2023, 12/13/2023 and 12/14/2023, in the presence of facility Management it was determined that the facility failed to ensure that 7 of 28 exit access stairwell doors tested, were capable of maintaining the 2 hour fire rated construction. This is evidenced by the following, On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a seven-story (7) building with four (4) exit stairwells (South, Center, West and North with illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building.	K 311	1. The following exit access doors- 7th floor center, 6th floor west, 4th floor south, 4th floor center, 3rd floor south, 3rd floor center, and 2nd floor south will be fixed to ensure they have a positive latch into their frames. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the regulation to ensure exit access doors have a positive latch in their frame. 4. The Maintenance Director/designee will audit 10 exit access doors monthly x 4 to ensure they have a positive latch into their frame. Audit findings will be shared with the QAPI committee monthly x 4.	2/20/24

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K 311	Continued From page 10 Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023 , 12/14 2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. Along the three (3) day tour, the surveyor inspected and conducted closure test of twenty-eight (28) exit access doors that lead into exit stairwells with the following results, On 12/12/2023: 1) At approximately 10:42 AM, when the surveyor tested the 7th. floor "Center" stairwell door by opening to a 90 degree opening to the door frame and allowed to self-close, the door closed into its frame and did not positive latch into its frame. This test was performed two additional times with the same results. The surveyor observed the doors latching mechanisms did not engage. This test was performed one additional time with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. On 12/13/2023: 2) At approximately 9:25 AM, when the surveyor tested the 6th. floor "West" stairwell door by opening to a 90 degree opening to the door frame and allowed to self-close, the door closed into its frame and did not positive latch into its frame. This test was performed one additional time with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door.	K 311		

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	315236	A. BUILDING **01** B. WING _____	**12/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 311	Continued From page 11 3) At approximately 10:21 AM, when the surveyor tested the 4th. floor "South" stairwell door by opening to a 90 degree opening to the door frame and allowed to self-close, the door closed into its frame and did not positive latch into its frame. This test was performed two additional times with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. 4) At approximately 10:26 AM, when the surveyor tested the 4th. floor "Center" stairwell door by opening to a 90 degree opening to the door frame and allowed to self-close, the door closed into its frame and did not positive latch into its frame. The surveyor observed the doors latching mechanisms did not engage. This test was performed two additional times with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. 5) At approximately 11:13 AM, when the surveyor tested the 3rd. floor "South" stairwell door by opening to a 90 degree opening to the door frame and allowed to self-close, the door closed into its frame and did not positive latch into its frame. The surveyor observed the doors latching mechanisms did not engage. This test was performed two additional times with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as	K 311		

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K 311	Continued From page 12 the primary exit to reach an exit discharge door. 6) At approximately 11:17 AM, when the surveyor tested the 3rd. floor "Center" stairwell door by opening to a 90 degree opening to the door frame and allowed to self-close, the door closed into its frame and did not positive latch into its frame. The surveyor observed the doors latching mechanisms did not engage. This test was performed two additional times with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. 7) At approximately 1:30 PM, when the surveyor tested the 2nd. floor "South" (Physical Therapy area) stairwell door by opening to a 90 degree opening to the door frame and allowed to self-close, the door closed into its frame and did not positive latch into its frame. The surveyor observed the doors latching mechanisms did not engage. This test was performed two additional times with the same results. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. The seven (7) stairwell doors would need to positive latch into their frames to maintain the 2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The facility RPOD and MD confirmed the findings at the time of the observations.	K 311		

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K 311	Continued From page 13 The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced	K 321		2/20/24

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K 321	Continued From page 14 by: Based on observation and review of facility provided documentation on 12/12/2023, 12/13/2023 and 12/14/2023, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a seven-story (7) building. Starting at approximately 10:00 AM on 12/12/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. During the three (3) day building tour the surveyor observed the following hazardous area that failed to have smoke resisting doors, On 12/12/2023: 1) At approximately 11:01 AM, during an inspection inside the seventh (7th.) floor Soiled Utility room identified the linen chute door when opened to a 90 degree opening the chute door did not close. This left an approximately 20 inch	K 321	1. The linen chute doors on floors 7,6,4, and 3 will be corrected to allow them to fully close without any gaps. The doors by central supply, medical records, and resident clothing room will be corrected to be self-closing. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the importance and regulation to ensure there are no gaps in the doors and that the doors are self-closing in hazardous areas. 4. An audit will be done by the maintenance director/designee monthly x 4 on 10 doors by hazardous areas to ensure they are self-closing, and on the linen chute doors to ensure they close fully. Audit findings will be shared with the QAPI committee monthly x 4.	

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K 321	Continued From page 15 by 20 inch opening from one floor to another floor. During a closure test of the corridor door was not smoke resistant. The surveyor observed an approximately 1/4 inch gap at the top of the door. With this corridor door not smoke resistant, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. On 12/13/2023: 2) At approximately 9:15 AM, during an inspection inside the sixth (6th.) floor Soiled Utility room identified the linen chute door when opened to a 90 degree opening the chute door did not latch into its frame. 3) At approximately 10:30 AM during an inspection inside the fourth (4th.) floor Soiled Utility room identified the linen chute door when opened to a 90 degree opening the chute door did not close. This left an approximately 20 inch by 20 inch opening from one floor to another floor. 4) At approximately 10:30 AM during an inspection inside the third (3rd.) floor Soiled Utility room identified the linen chute door when opened to a 90 degree opening the chute door did not close. This left an approximately 20 inch by 20 inch opening from one floor to another floor. 5) At approximately 1:20 PM, during an inspection of the 2nd. floor Central supply room, the surveyor observed the corridor door had no means to self-close the door into its frame. The room was larger than 50 square feet and had multiple combustible cardboard boxes and other combustible products.	K 321		

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K 321	Continued From page 16 With this corridor door not closing into its frame, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 6) At approximately 1:30 PM, during an inspection of the 2nd. floor Medical Records room, the surveyor observed the corridor door had no means to self-close the door into its frame. The room was larger than 50 square feet and had multiple combustible cardboard boxes and multiple combustible medical records. With this corridor door not closing into its frame, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an emergency evacuation diagram posted on the corridor wall identified these two rooms are the primary and/ or secondary exit access to reach an exit On 12/14/2023: 7) At approximately 1-:33 AM, the surveyor observed the 2nd. floor Resident Clothing room corridor door had no means to self-close into its frame. The room was larger than 50 square feet and had multiple items of combustible Residents clothing hanging on several clothing racks.. With this corridor door not closing into its frame, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The RPOD and MD confirmed the findings at the times of observations.	K 321		

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K 321	Continued From page 17 The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 12/12/2023, 12/13/2023 and 12/14/2023 in the presence of the facility management, it was determined that the facility failed to Ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide all mandatory	K 345	1. The sensitivity testing of the smoke detectors will be completed. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the regulation of having a sensitivity testing of smoke detectors every alternate year. 4. Audit will be done by the maintenance director/designee annually to ensure the facility is up to date with the required smoke detector sensitivity testing. Audit findings will be shared with the QAPI committee annually.	2/20/24

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K 345	Continued From page 18 inspections that had been conducted from 01/01/2022 through 12/14/2023 for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. Later on 12/12/2023 at approximately 12:05 PM, during the documentation review of the mandatory inspections of the facility's Fire Alarm and Detection system semi-annual (every 6 months) inspections for the previous 22 months identified the system had the following semi-annual fire alarm and detection system inspection reports, The surveyor reviewed the following Fire Alarm and Detection system inspections, - 01/11/2022, 08/11/2022, 01/18/2023 and 07/26/2023 semi-annual inspections. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. At approximately 2:05 PM on 12/12/2023, the surveyor asked the facility RPOD and MD they may have to call the fire alarm and detection vendor and ask for a copy of the last smoke detector sensitivity testing, and to provide the copy of the smoke detector sensitivity testing to the surveyor by 12/13/2023 (day two of survey) for review. On 12/13/2023 at approximately 8:44 AM, the RPOD told the surveyor that he would have to call the previous Fire Alarm and Detection Vendor to ask about the smoke detector sensitivity testing of the fire alarm and detection system. On 12/14/2023 at approximately 9:16 AM, the RPOD told the surveyor that he smoke detector	K 345		

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K 345	Continued From page 19 sensitivity testing had not been conducted . Later at approximately 1:25 PM during a tour of the building in the presence of the RPOD and MD, an inspection inside of the 2nd. floor Central Supply room was performed. The surveyor observed a smoke detector base (hard wired) that had no smoke detector attached to the base. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
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:	K 351		2/20/24

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K 351	Continued From page 20 Based on observation, interview and review of facility provided documentation on 12/12/2023, 12/13/2023 and 12/14/2023, in the presence of facility management it was determined that: The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a seven-story (7) building with four (4) exit stairwells (South, Center, West and North) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. There are common areas and Resident sleeping rooms on the 3rd., 4th., 5th., 6th. and 7th. floors. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023, 12/14/2023 in the presence of the facility's RPOD and MD a tour of the facility was conducted. Along the three (3) day tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage:	K 351	1. Sprikler coverage will be installed in the roof level cable room, roof level elevator mechanical equipment room, 2nd floor physical therapy internet and phone closet, 2nd floor housekeeping closet, 2nd floor laundry clothing closet, and in a 1st floor closet. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was reeducated on the importance and regulation of proper fire sprinkler coverage. 4. The maintenance director/designee will audit 10 rooms monthly x 4 months to ensure proper fire sprinkler coverage is in place. Audit findings will be shared with the QAPI committee monthly x 4.	

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K 351	Continued From page 21 On 12/12/2023: 1) At approximately 10:57 AM, the surveyor observed no evidence of fire sprinkler coverage inside the roof level 9'-6" by 14' Cable Room. The surveyor observed a sprinkler pipe in the room that had an end cap installed on the pipe. At this time the surveyor asked the MD, Do you see any sprinklers inside the room. The MD looked up and around and said, no. 2) At approximately 11:01 AM, the surveyor observed no evidence of fire sprinkler coverage inside the roof level elevator mechanical equipment room. On 12/13/2023: 3) At approximately 1:07 PM, the surveyor observed no evidence of fire sprinkler coverage inside the 2nd. floor Physical Therapy area 12" by 4' Internet and Phone closet. On 12/14/2023: 4) At approximately 10:28 AM, the surveyor observed no evidence of fire sprinkler coverage inside the 2nd. floor 32' by 4'-6" Housekeeping closet. 5) At approximately 10:33 AM, the surveyor observed no evidence of fire sprinkler coverage inside the 2nd. floor 40" by 4' Laundry Clothing closet. 6) At approximately 10:58 AM, the surveyor observed no evidence of fire sprinkler coverage inside a 1st. floor 21" by 3' closet. At this time the surveyor asked the MD, which office is this. The MD told the surveyor its Crouse's office.	K 351		

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K 351	Continued From page 22 The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 353 SS=E	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 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 documentation review, the facility failed to ensure: 1) Sprinkler gauges were calibrated or replaced every five years; 2) Conduct a 5 year internal piping	K 353	1. A 5-year internal pipe inspection will be completed. The gauge on the 7th floor for the dry sprinkler will be replaced.	2/20/24

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K 353	Continued From page 23 inspection in accordance with NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems (2011 edition) sections 26.1. Findings include: On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide all mandatory inspections for review later. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023 and 12/14/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. On 12/12/2023 at approximately 11:31 AM, the surveyor observed on the 7th. floor the dry sprinkler system gauge was dated 2017. There was no tag or sticker which indicated when the last time the sprinkler gauge was calibrated or replaced. Neither the RPOD nor the MD could identify when the last time the sprinkler gauge was last calibrated. Later at approximately 12:15 PM, during the mandatory inspection review of the sprinkler system revealed no evidence of a 5 year internal pipe inspection in accordance with NFPA 25. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39-31.2(e) NFPA 13, 25	K 353	2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the proper inspection of the sprinkler gauge and the regulation of the 5-year internal pipe inspection. 4. An audit will be completed by the maintenance director annually to ensure gauges and inspections are up to date. Audit findings will be shared with the QAPI committee annually.	

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K 355	Continued From page 24	K 355		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 12/12/2023, 12/13/2023 and 12/14/2023 in the presence of facility management, it was determined that the facility failed to: 1) Install portable fire extinguishers with-in the required height for 33 of 48 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection	K 355	1. All the fire extinguishers identified will be corrected to ensure they are within the required installation heights. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was reeducated on the regulation of proper placement of fire extinguishers. 4. Audit will be done by the maintenance director/designee monthly x 4 on 10 fire extinguishers to ensure proper placement. Audit findings will be shared with the QAPI committee monthly x 4.	2/20/24

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K 355	Continued From page 25 was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. The findings include the following, On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a seven-story (7) building. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023, 12/14/2023 in the presence of the facility's RPOD and MD a tour of the facility was conducted. During the three day building tour the surveyor	K 355		

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K 355	Continued From page 26 observed and inspected forty-eight (48) portable fire extinguishers in various locations. The surveyor observed and recorded measurements of thirty-three (33) portable fire extinguishers that were observed and appeared not installed with-in the required installation heights in the following areas, - The 7th. floor had 5 of 6 extinguishers observed in various locations installed too high. The surveyor measured and recorded the fire extinguishers were mounted between 5'- 5" and 5'-6-1/2" to the center of the pressure indicating needle. - The 6th. floor had 5 of 6 extinguishers observed in various locations installed too high. The surveyor measured and recorded the fire extinguishers were mounted between 5'- 3" and 5'-5-1/2" to the center of the pressure indicating needle. - The 5th. floor had 4 of 6 extinguishers observed in various locations installed too high. The surveyor measured and recorded the fire extinguishers were mounted between 5'- 3" and 5'-10" to the center of the pressure indicating needle. - The 4th. floor had 5 of 6 extinguishers observed in various locations installed too high. The surveyor measured and recorded the fire extinguishers were mounted between 5'-4-1/2" and 5'-7" to the center of the pressure indicating needle. - The 3rd. floor had 3 of 6 extinguishers observed in various locations installed too high. The surveyor measured and recorded the fire	K 355		

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K 355	Continued From page 27 extinguishers were mounted between 5'-3" and 5'-6" to the center of the pressure indicating needle. - The 2nd. floor had 3 of 9 extinguishers observed in various locations installed too high. The surveyor measured and recorded the fire extinguishers were mounted between 5'-4" and 5'-6" to the center of the pressure indicating needle. - The 1st. floor had 7 of 9 extinguishers observed in various locations installed too high. The surveyor measured and recorded the fire extinguishers were mounted between 5'-4" and 5'-10-1/2" to the center of the pressure indicating needle. The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 362 SS=E	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the	K 362		2/20/24

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K 362	Continued From page 28 underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 12/12/2023, 12/13/2023 and 12/14/2023, in the presence of facility management it was determined that the facility failed to maintain the 1/2 hour fire rated construction for corridor walls. The evidence of this deficient practice includes the following, On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a seven-story (7) building. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023, 12/14/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. Along the three (3) day building tour the surveyor observed that failed to maintain the 1/2 hour fire	K 362	1. The offices/rooms identified on each floor without proper fire rated construction will be corrected. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department has been reeducated on the regulation of exit access corridors requiring fire rated construction. 4. Audit will be done by the maintenance director/designee monthly x 4 to ensure exit access corridors have the required fire rated construction. Audit findings will be shared with the QAPI committee monthly x 4.	

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K 362	Continued From page 29 rated construction in exit access corridors in the following locations, On 12/12/2023: 1) On the 7th. floor, the surveyor observed and measured a 30 inch high by 48 inch opening in the Residents Concierge office (across from elevators #3 and #4) with two Plexiglas sliding windows. The surveyor measured a 1/4 inch gap between the meeting edges of the two (2)Plexiglas windows. On 12/13/2023: 2) On the 6th. floor, the surveyor observed and measured a 30 inch high by 48 inch opening in the Nurse Practitioner office (across from elevators #3 and #4) with two Plexiglas sliding windows. The surveyor measured a 1/4 inch gap between the meeting edges of the two (2)Plexiglas windows. 3) On the 5th. floor, the surveyor observed and measured a 30 inch high by 48 inch opening in the Director of Activities office (across from elevators #3 and #4) with two Plexiglas sliding windows. The surveyor measured a 1/4 inch gap between the meeting edges of the two (2)Plexiglas windows. 4) On 4th. floor, the surveyor observed and measured a 30 inch high by 48 inch opening in the office across from elevators #3 and #4 with two Plexiglas sliding windows. The surveyor measured a 1/4 inch gap between the meeting edges of the two (2)Plexiglas windows.	K 362		

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K 362	Continued From page 30 5) On 3rd. floor, the surveyor observed and measured a 30 inch high by 48 inch opening in the office across from elevators #3 and #4 with two Plexiglas sliding windows. The surveyor measured a 1/4 inch gap between the meeting edges of the two (2)Plexiglas windows. 6) On the 2nd. floor, the surveyor observed and measured a 5'-7" by 38" section of wallboard removed on both sides of the metal studs. The facility installed a glass mirror to cover the opening through the 1/2 hour fire rated corridor wall. The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 19.3.6.2, 19.3.4.2.7	K 362		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller	K 363		2/20/24

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K 363	Continued From page 31 latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 12/12/2023, 12/13/2023 and 12/14/2023, in the presence of facility management it was determined that the facility failed to ensure that 4 of 36 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 12/12/2023 (day one of survey) during the	K 363	1. The gaps in the door closures by rooms 737, 742, 6th floor shower room next to center stairwell, and 3rd floor clean linen corridor will be corrected. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was reeducated on the regulation of doors needing to be able to resist the passage	

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K 363	Continued From page 32 survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested how many Resident sleeping rooms are in the facility. The MD told the surveyor he thinks 222 Resident sleeping rooms. A review of the facility provided lay-out identified the facility is a seven-story (7) building with Resident sleeping rooms on the 3rd., 4th., 5th., 6th. and 7th. floors. Starting at approximately 10:00 AM on 12/12/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. During the three (3) day tour of the facility the surveyor performed closure tests of the thirty-six (36) doors in the corridors with the following results, On 12/12/2023: 1) At approximately 11:20 AM, the surveyor observed on the 7th. floor Resident room #737 had an approximately 1/4 inch gap at the top of the door when in the closed position. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2) At approximately 11:28 AM, the surveyor observed on the 7th. floor Resident room #742 had an approximately 1/4 inch gap at the top of the door when in the closed position. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the	K 363	of smoke. 4. Audit will be done by the maintenance director/designee monthly x 4 months on 10 doors to ensure there are no gaps when closed. Audit findings will be shared with the QAPI committee monthly x 4.	

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K 363	Continued From page 33 event of a fire. On 12/13/2023: 3) At approximately 9:09 AM, the surveyor observed on the 6th. floor the shower room (next to the Center stairwell) corridor door was in the closed position there was a 1/2 inch gap along the top of the door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 4) At approximately 11:35 AM, the surveyor observed on the 3rd. floor that when the Clean Linen corridor door was in the closed position there were two (2) 1/4 inch holed drilled through the door and a 1/4 inch gap along the top of the door.. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's	K 521		2/20/24

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K 521	Continued From page 34 specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 12/12/2023, 12/13/2023 and 12/14/2023 in the presence of facility management, it was determined that the facility failed to : 1) Ensure that the facility's ventilation systems were being properly maintained for 3 of 14 Resident bathroom exhaust systems, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested ,how many Resident sleeping rooms are in the facility. The MD told the surveyor that there are 222 Resident sleeping rooms. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023 and 12/14/2023 in the presence of the facility's RPOD and MD a tour of the facility was conducted. Along the three (3) day building tour, the surveyor inspected fourteen (14) Resident sleeping room	K 521	1. The exhaust fans in the resident bathrooms by room 712, 620, and 334 will be fixed. 2. The residents in the listed rooms have the potential to be affected by this deficient practice. 3. The maintenance department was reeducated on ensuring proper working exhaust fans in resident bathrooms. 4. The maintenance director/designee will audit 10 resident bathroom exhaust fans monthly x 4 months to ensure they are working properly. Audit findings will be shared with the QAPI committee monthly x 4 months.	

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SINAI POST ACUTE NURSING AND REHAB CENTER	**65 JAY STREET** **NEWARK, NJ 07103**

(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 521	Continued From page 35 bathrooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 3 of 14 resident bathrooms in the following locations: On 12/12/2023: 1. At approximately 10:25 AM, inside Residents room #712 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. On 12/13/2023: 2. At approximately 9:20 AM, inside Resident room #620 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 11:30 AM, inside Resident room #334 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NFPA 90A.	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315236	A. BUILDING **01** B. WING _____	**12/22/2023**

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K 521	Continued From page 36 NJAC 8:39- 31.2 (e).	K 521		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 12/12/2023, 12/13/2023 and 12/14/2023, in the presence of facility management, it was determined that the facility failed to ensure that 4 of 6 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily	K 911	1. The electrical outlets in the pantries on floors 6, 5, 4, and 3 have been replaced with a GFCI outlet. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was reeducated on the regulation that electrical outlets in wet areas are required to be GFCI. 4. The maintenance director/designee will audit 10 wet areas monthly x 4 to ensure the outlets within 6 feet of them are GFCI. Audit findings will be shared with the QAPI committee monthly x 4.	2/20/24

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K 911	Continued From page 37 accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked "How many Resident sleeping rooms are in the facility." The MD told the surveyor that there are 222 Resident sleeping rooms in the facility. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023 and 12/14/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. During the three (3) day tour of the facility, the surveyor observed and tested six (6) electrical outlets in wet (with-in 6 feet of a sink) locations with four (4) electrical outlets that failed to de-energize when tested in the following location, On 12/13/2023: 1. At approximately 9:36 AM, inside the 6th. floor Activities/ Pantry room, one GFCI electrical outlet located 28" from the hand washing sink when tested with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as	K 911		

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K 911	Continued From page 38 required by code. 2. At approximately 10:10 AM, inside the 5th. floor Activities/ Pantry room, one Duplex electrical outlet located 46" from the hand washing sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 3. At approximately 10:44 AM, inside the 4th. floor Activities/ Pantry room, one Duplex electrical outlet located 4'- 10" from the hand washing sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 4. At approximately 11:40 AM, inside the 3rd. floor Activities/ Pantry room, one Duplex electrical outlet located 44" from the hand washing sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 914 SS=E	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	K 914		2/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315236	A. BUILDING 01 B. WING	12/22/2023

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K 914	Continued From page 39 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 observation and document review on 12/12/2023 and 12/13/2023, it was determined that the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 (2012 edition) Health Care Facilities Code section 6.3.4.1.3. This deficient practice had the potential to affect all 112 residents. On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) to provide all mandatory inspections from 01/01/22 to 12/11/2023 for review later. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023,	K 914	1. An actual test of the electrical system will be conducted. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was reeducated on the regulation of annual electrical system testing. 4. The maintenance director/designee will audit annually to ensure the required electrical system testing has been completed. Audit findings will be shared with the QAPI committee annually.	

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K 914	Continued From page 40 12/14/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. Along the three (3) day tour of the facility the surveyor observed the facility less than Hospital Grade (electrical outlets identified with a Green Dot) electrical outlets in Resident rooms and common areas. Later at approximately 12:15 PM a review of the facility provided annual Inspections reads in part: 1) Contracted vendors 2022 annual electrical inspection. "On October 22, 2022, I did an annual visual electrical inspection of Sinia Nursing and Rehabilitation facility. Upon completion of my visual electrical survey, I was satisfied at that time that the facility was in compliance with the National Electrical Code, State and local standards." 2) Contracted vendors 2023 annual electrical inspection, "On October 14, 2023, I did an annual visual electrical inspection of Sinia Nursing and Rehabilitation facility. Upon completion of my visual electrical survey, I was satisfied at that time that the facility was in compliance with the National Electrical Code, State and local standards." The contracted vendor failed to test receptacle outlets for compliance with outlet retention force annually.. The Administrator was informed of the deficiency during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39-31.2(e) NFPA 99 - 6.3.4.1.3	K 914		

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K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on	K 918	1. A remote emergency stop button for	2/20/24

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K 918	Continued From page 42 12/12/2023 and 12/14/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 12/12/2023 (day one of survey) during the survey entrance at approximately 9:30 AM, a request was made to the Administrator, Regional Plant Operations Director (RPOD) and Maintenance Director (MD) if the facility had an Emergency Generator. The MD told the surveyor, yes we have one Kohler Diesel Emergency Generator. Starting at approximately 10:00 AM on 12/12/2023 and continued on 12/13/2023 and 12/14/2023 in the presence of the facility's RPOD and MD a tour of the building was conducted. On 12/14/2023 during a tour of the building with the RPOD and MD at approximately 11:22 AM, an inspection outside of the building, where the Diesel emergency generator was located was performed. The surveyor observed the emergency stop button was located inside the generator metal housing on the control panel on the generator. At this time the surveyor asked the RPOD, Do you have a remote emergency stop button for the generator. The RPOD said, no. The RPOD and MD confirmed the findings at the times of observations. The Administrator was informed of the deficiency	K 918	the generator will be installed. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was reeducated on ensuring that the generator has a remote emergency stop button. 4. The maintenance director will audit the generator monthly x 4 to ensure the remote emergency stop button is in the proper place. Audit findings will be shared with the QAPI committee monthly x 4.	

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K 918	Continued From page 43 during the survey exit on 12/14/2023 at approximately 1:35 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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
315236 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/23/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SINAI POST ACUTE NURSING AND REHAB CENTER	65 JAY STREET NEWARK, NJ 07103

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	02/20/2024	LSC K0225	02/20/2024	LSC K0291	02/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	02/20/2024	LSC K0311	02/20/2024	LSC K0321	02/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	02/20/2024	LSC K0351	02/20/2024	LSC K0353	02/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	02/20/2024	LSC K0362	02/20/2024	LSC K0363	02/20/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	02/20/2024	LSC K0911	02/20/2024	LSC K0914	02/20/2024

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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
315236 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/23/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction				
Reg. # NFPA 101	Completed				
LSC K0918	02/20/2024				

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? ☐ YES ☐ NO
12/22/2023	