PRINTED: 09/27/2024 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING				C 29/2024
NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 017	LUIZULA
				65 J	IAY STREET		
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		NEV	WARK, NJ 07103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
	Complaint # NJ 1754	415					
	Survey Dates: 07/11/	24 through 07/15/24					
	Census: 406						
	Sample Size: 11						
	42 CFR PART 483, S	OT IN SUBSTANTIAL ITHE REQUIREMENTS OF SUBPART B, FOR LONG TIES BASED ON THIS					
	requirements of 42 C	substantial compliance with FR Part 483, for Long Term encies were cited for this					
	Acute Center from 07	was conducted at Sinai Post 7/11/24 through 07/15/24 to e with 42 CFR Part 483, for ities.					
	Immediate Jeopardy CFR 483.10 (a) (1)-R Rights (F 550, F 557, the facility failed to proceed to the facility failed to proceed to the failed	inding which constituted (IJ) was identified under 42 Resident Rights/Exercise , F 561, F 603, and F 604) as rovide 11 of 11 (Resident #1, 2, 3, 4, 5, 4) the autonomy to participate ommunity dining, serving manner, freely communicate we rooms at will and were 6.4(b)(1). Also, 42 CFR In who failed to ensure the policies and procedures for					
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE

Electronically Signed 08/07/2024

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.

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _				C 29/2024
NAME OF PROV	DER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	DE	1 011	LUILULT
				65 JAY STREET			
SINAI POST A	CUTE NURSING AN	D REHAB CENTER		NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
Reas research (Resignation of the signature of the signat	policies and procestraints and seclusisure 11 of 11 NJE esident #1, 2, 3, 4, and Admission Agree facility. Deference: The Centre edicaid Services (Corveyors on Federarvices to Justice Inv. /23/2016 S & C 16 arsing Facilities must tonomy and choice acticable regarding eryday lives and rehts as nursing hom According to the Advas admitted to the Jex order 26.4 NJ ex order 26.4 NJ	dures to prevent physical on. The also failed to also failed also	F				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING		
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION			(X5) COMPLETION DATE
F 000	Assessment dated assessed as having assessed as having assessed as having a consistency or NJ Ex Order. A review were initiated regal activities of the medical recording to the medical recording to the medical recording to the management of the management of the medical recording to the management of the management	g to the Admission Resident #2 was g no NEX ORDITION and utilized no der 26.4(b)(1). According to the ment dated NEX ORDITION (I). Resident 26.4b1 V of the CP revealed no CP reding supervision with ADLs, s, or NEX ORDITION Further review ord revealed that Resident #2 cility AA. The Comprehensive (MDS) was in progress and iew. Resident #3 was Ab1 Resident #3 was Ab1 A review of the Dusty with diagnoses Ab1 A review of the required activities, or review of the medical record dent #3 did not sign the facility tensive Minimum Data Set tress and unavailable for A Admission Record Resident to the facility with diagnoses Ab1 A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A Admission Record Resident to the facility with diagnoses A D1 A According to the ment dated	FO				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE : COMPI	
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	ID REHAB CENTER	'	STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE
F 000	activities, or Admission summary at 1:37 PM	According to the progress note dated, revealed the resident wither review of the medical Resident #4 did not sign the prehensive Minimum Data ogress and unavailable for admission Record, Resident the facility with diagnoses b1 According to the Admission According to the Admission Record of the CP revealed no CP (Corder 26.4b1) Further review of the medical Resident #5 ty AA. The Comprehensive MDS) was in progress and w. Admission Record Resident #5 ty AA. The Comprehensive MDS) was in progress and w. Admission Record Resident the facility with diagnoses order 26.4b1. According to the ent dated According	FO				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE COMP	LETED
		315236	B. WING _			07/2	29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	ID REHAB CENTER	1	STREET ADDRESS, CITY, STATE, ZIP COE 65 JAY STREET NEWARK, NJ 07103	ÞΕ	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	regarding supervision medical record reveal sign the facility AA. To Data Set (MDS) was for review. 7. According to the Af #7 NJ ex order 26 Admission Assessmant at the Admission Assessmant was assess and utilized NJ ex order 26.4 NJ ex order 26.4 review of the CP reveal medical record reveal sign the facility AA. To	Further review of the aled that Resident #6 did not the Comprehensive Minimum in progress and unavailable admission Record Resident 6.4b1 According to the ent dated as having order 26.4b1 nission summary note dated M, revealed the resident was	FC				
	Assessment dated Admission progress PM, indicated the result the CP revealed no supervision with ADI Further revealed that Reside	According to the Admission According to the resident and Nuexorder 26.461 According to the According to the note dated Nuexorder 26.461 A review of CP were initiated regarding					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		315236	B. WING _			C 07/29/2024
	ROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STAT 65 JAY STREET NEWARK, NJ 07103	E, ZIP CODE	0112012024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)	
F 000	9. According to the A #9 was admitted to t which included Admission Assessm NJ ex order 26.4 Nex order 26.4 Nex order 26.4 Lex order 26.4 Admission Assessm review. 10. According to the #10 was admitted to NJ ex order 26.4 Admission Assessm resident NJ ex order 26.4 Admission Summ Lex order 26.4 Admission Summ Lex order 26.4 Resident #10 did no Comprehensive Min progress and unavail	Admission Record Resident he facility with diagnoses According to the ent dated According to the were initiated regarding activities, or eview of the medical record ent #9 did not sign the facility ess and unavailable for Admission Record Resident the facility with diagnoses b1 According to the ent dated According	F	000		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	· ,	TE SURVEY MPLETED
		315236	B. WING _			C 7/29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 65 JAY STREET NEWARK, NJ 07103	•	1120/2027
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 000	which included Admission Assess resident NJ ex of Admission Assess resident NJ ex of According to the partial extended the facility AAD at a Set (MDS) where the American extended the facility and the facility will take to occurring or recurrective action paractice including: were discharged for the facility will not the survey team on 7/29/24, and designed for the facility will not the survey team on 7/29/24, and designed for the facility will not the survey team on 7/29/24, and designed for the facility will not the survey team on 7/29/24, and designed for the facility will not the survey team on 7/29/24, and designed for the facility will not the survey team on 7/29/24, and designed for the facility will not the facility w	According to the sment dated occording to the region of the resident occording to the region of the resident occording to the residen	F			
F 550 SS=K	were removed as Resident Rights/E		F t	550		8/20/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X:	(X3) DATE SURVEY COMPLETED		
		315236	B. WING _			C 07/29/2024
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103	,	01720/202-
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A fact with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The fapromote the rights of \$483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of services residents regardles. §483.10(b) Exercise The resident has the rights as a resident or resident of the USA83.10(b)(1) The resident can exercisinterference, coerciffrom the facility.	and communication with and and services inside and including those specified in solidity must treat each resident gnity and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's incility must protect and of the resident. Facility must provide equal are regardless of diagnosis, an, or payment source. A facility maintain identical policies and a transfer, discharge, and the es under the State plan for all is of payment source. The of Rights are right to exercise his or her of the facility and as a citizen inted States. Facility must ensure that the se his or her rights without on, discrimination, or reprisal	F 5	50		
	free of interference	resident has the right to be , coercion, discrimination, and cility in exercising his or her				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			07/2	29/2024
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD)E	1 0177	20/2024
CINAL DO	ST ACUTE NURSING AN	D DELIAB CENTED		65 JAY STREET			
SINAIPO	ST ACUTE NURSING AN	D REHAD CENTER		NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI		(X5) COMPLETION DATE
F 550	Continued From page	e 8	F 5	550			
	rights and to be supplexercise of his or her subpart. This REQUIREMENT by: Complaint # NJ 1754 Based on observation and review of pertined determined that the factor of 11 NJ Ex Order afforded the autonom activities, community dignified manner, free visitors, leave rooms NJ Ex Order 26.4(b)(1) for 7, 8, 9, 10, and 11). Trespectfully and in a clikelihood to cause NJ Ex Order 26.4(b)(1) that immediately jeop safety of the NJ Ex Order 26.4(b)(1). The Immediate Jeopa the date that the first admitted to the facility. The IJ was ide Residents #1, 2, 3, 4, were observed being NJ ex order 26.4th.	orted by the facility in the rights as required under this is not met as evidenced at 15 In, interview, record review, and facility documents, it was acility failed to ensure that 11 26.4(b)(1)) were by to participate in group dining, serving meals in a sely communicate with at will and be free from a fely communicate with at will and be free from a fely communicate with at will and be free from a fely communicate with at will and be free from a fely communicate with at will and be free from a fely communicate with at will and be free from a fely communicate with at will and be free from a fely communicate with a fellow the facility to the fellow and the fellow and the facility which resulted and the facility which resulted are for the facility which resulted and was facility which resulted and was for the facility which resulted a		1. All NJ Ex Order 26.4(b) been discharged from the face 2. All Justice involved Reside potential to be affected by this practice. 3. All administrative staff will I reeducated on the importance that residents are afforded the to participate in group activitie communal dining, served medignified manner, freely communitations, leave rooms at will arrom physical restraints. 4. The Administrator/designeer residents a month x 4 months they are being afforded auton participate in group activities, dining, served meals in a dignanner, freely communicate leave rooms at will and be free physical restraints. Audit findishared with the QAPI commit x 4 months.	ents have to see autonomes, als in a municate wond be free will audit is to ensure communatified with visitoe fromes mings will be	the t t ring ny with e al ors,	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315236	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103		7/29/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	existed which also or Quality of Care (SQC Regulations (CFR) 4 treat each resident we care for each resident environment that proenhancement of their each residents' indiversed protect and promote. An acceptable remove 7/29/24 at 9:59 AM, facility will take to proccurring or recurring corrective action plan practice including: All were discharged from The facility will no long. The survey team ver on 7/29/24 and determined as of 7/26/2024. The findings were as Reference: The Center Medicaid Services (Conveyors on Federal Services to Justice In 12/23/2016 S & C 16 Nursing Facilities muautonomy and choice practicable regarding the side of the surveyors of the center	was informed of the IJ on that an immediate jeopardy onstituted Substandard (2) for 42 Code of Federal (83.10 (a) (1). A facility must with respect and dignity and the in a manner and an imotes maintenance or requality of life and recognize iduality. The facility must the rights of the resident. Wal plan was received on indicating the action the event serious harm from g. The facility implemented a into remediate the deficient (INJ EX Order 26.4(b)(1)) in the facility as of inger admit (INJ was removed) If follows: Iters for Medicare and (INS) updated Guideline to all Requirements for Providing anyolved individuals, revised (5-21-ALL documented Skilled last permit residents to have the to the maximum extent go how they wish to live their eceive care with the same	F 5	50			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315236	B. WING		C 07/29/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/23/2024
SINAI POS	ST ACUTE NURSING A	ND REHAB CENTER	1	NEWARK, NJ 07103	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIO
F 550	Continued From page 10 The provided the surveyors with multiple facility policies including "The dining environment and activity programs". The dining environment policy with a revised date of January 2024, included under the policy section, "A pleasant environment is essential to promoting a positive dining experience." The activity programs policy with a revised date of February 2024, included under the policy interpretation and implementation section, "1. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. 3. Our activity programs consist of individual and small and large group activities that are designed to meet the needs and interests of each resident and include, as a minimum: J) Social activities are scheduled to increase self-esteem, to stimulate interest and friendships, and provide fun and enjoyment."		F 550		
	"Resident Rights" ir would be treated ed sex, ethnicity, religion or mental disability, sexual orientation, expression. The reswith dignity and res	ated 02/2024 and titled, indicated that "all residents qually regardless of age, race, ion, culture, language, physical socioeconomic status, sex, ior gender identity or sident has a right to be treated pect including being free from mical restraints imposed for			
	resident has a right the community and activities both inside right to receive visit subject to the reside when applicabler groupsthe right for	cipline or convenience. The to interact with members of participate in community e and outside the facility the ors of his or her own choosing ent's right to deny visitation ight to participate in family or personal privacy includes nedical treatment, telephone			

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		315236	B. WING _			C 07/29/2024
NAME OF PROVIDER OF		D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 65 JAY STREET NEWARK, NJ 07103	CODE	
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA	DATE
Tommumeeting 1. Accord #1 was NJ ex Admiss #1 NJ NJ ex Accord NJ ex Order 28 Admiss Minimumer 20 Care P reveale Admiss Minimumer 20 CP reve reveale AA. The (MDS) review.	gs of family and ording to the Adadmitted to the Order 26.4 iion Assessment ex Order 26.4 iing to the Admitted	dmission Record, Resident are facility with diagnoses b1 According to the and dated are resident was review of the Individualized and NJ ex Order 26.4b1 According to the and dated are resident was review of the Individualized and NJ ex Order 26.4b1 According to the and dated are resident was revealed the resident was review of the Individualized and NJ ex Order 26.4b1 According to the and dated are resident was revealed the resident was review of the medical record and #1 did not sign the facility at (AA). The Comprehensive MDS) was in progress and w.	F5	550		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		315236	B. WING		C 07/29/2024		
	ROVIDER OR SUPPLIER	AND REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103			112012027	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 550	According Assessment dated CP revealed NJ ex Further revealed that Resid AA. The Comprehe (MDS) was in progreview. 4. According to the #4 was admitted to NJ ex Order 26 Admission Assessment Admiss	dent #3 did not sign the facility ensive Minimum Data Set ress and unavailable for Admission Record Resident the facility with diagnoses Ab1 According to the medical resident the facility with diagnoses Ab1 According to the medical the resident the facility with diagnoses Ab1 According to the medical the resident the facility with diagnoses Ab1 According to the medical the resident the facility with diagnoses Ab1 According to the medical the resident the facility with diagnoses Ab1 According to the medical the resident the facility with diagnoses Ab1 According to the resident the medical the facility with ADLs, the facility with diagnoses Admission-making. A the facility with diag	F 58	50			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/29/2024		
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 65 JAY STREET NEWARK, NJ 07103	DE	, , , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE	
F 550	of the medical record did not sign the facilit Minimum Data Set (Nunavailable for review 6. According to the A#6 was admitted to the NJ ex Order 26.4 Admission Assessmeresident was assess and utilized no According to the Sociated Nunavailable for Mental sindicating that the result indicating that the result indicatin	Further review I revealed that Resident #5 ty AA. The Comprehensive MDS) was in progress and Moscording to the ent dated Next Order 26.4b1 Lacording to the	F5	550				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			
		315236	B. WING _	B. WING			C 07/29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	ID REHAB CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 65 JAY STREET NEWARK, NJ 07103)E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
F 550	activities, or medical record revealed and set (MDS) was for review. 8. According to the Alexandrian and set (MDS) was admitted to the set of the Alexandrian and set of the CP revealed not supervision with ADL supervis	Further review of the aled that Resident #7 Local According to the facility with diagnoses and unavailable According to the mote dated According to the medical record not #8 did not sign the facility sive Minimum Data Set se and unavailable for According to the medical record not #8 did not sign the facility sive Minimum Data Set se and unavailable for According to the ent dated According to the medical record not #8 did not sign the facility sive Minimum Data Set se and unavailable for According to the ent dated According to th	F	550				
		nt #9 did not sign the facility sive Minimum Data Set						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY ETED
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 0 65 JAY STREET NEWARK, NJ 07103	CODE	V./-	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT		(X5) COMPLETION DATE
F 550	10. According to the #10 was admitted NJ ex Order 26 NJ ex Order 26 NJ ex Order 26 Admission Assess resident was assest at 2:40 P at 2:4	ne Admission Record Resident to the facility with diagnoses 3.4b1 3.4b1 According to the ment dated According to the control of the CP revealed according supervision According to the CP revealed according supervision According to the ment dated According	F 5	550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(2	(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 65 JAY STREET NEWARK, NJ 07103	CODE	01123/202-4	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCY	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE	
F 550	prohibited by the supervisor of the and stated that all required approval to have inte On 07/11/24 at 11 allowed by the H4 NJ ex Order resident stated that NJ ex Order and NJ ex Order 26.451 . Resident stated that all required approval to have interested approval.	y surveyor #1 and #2, and was JJ Ex Order 26.4(b)(1). A J Ex Order 26.4(b)(1) was interviewed NJ Ex Order 26.4(b)(1) office or rviews or visitation. 20.5 AM, Surveyor #2 was Order 26.4(b)(1) to interview Resident 26.4b1 The at they NJ ex Order 26.4b1 J ex Order 26.4b1 J ex Order 26.4b1 NJ ex Order 26.4b1 NJ ex Order 26.4b1 NJ ex Order 26.4b1	F 5	550			
	On 07/11/24 at 11 Surveyor #2 intervent who employed by the free explained what he admitted to the fact admission process explained the process explained the process explained to the fact admitted to the fact admitted to the fact list of resident right information and particles.	ent #1, NJ ex Order 26.4b1 242 AM, Surveyor #1 and riewed the US FOIA (B) (6) stated that she had been acility for about role was when residents were cility and stated that during the s, NJ ex order 26.4b1 She ress of completing an advanced e planning and held Care Plan ted that when the were cility she provided them with a tes, advanced directives, billing ain management. She stated eral regulations in nursing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 7/29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 65 JAY STREET NEWARK, NJ 07103		1112312024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 550	and not being able to form a NJ Ex Order 26.4(residents NJ ex order 26.4(residents NJ ex order 26.4(residents NJ ex order 26.4). The State of the server of	ident in the room was a b)(1). She stated that the ler 26.4b1 winst the federal regulations. AM, Surveyors #3, #4, and d floor U.S. FOIA (b) (6) who stated the ler 26.4b1 who shall be served on a disposable tray ler 26.4b1 who shall be served on a disposable tray ler 26.4b1 who shall be served in ler 26.4b1 who shall be served that the non utilizing non disposable hware (plates, cups and	F	550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _		C 07/29/2024	
	ROVIDER OR SUPPLIER	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103	1 0112512024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 550		e 18 e for both Resident #8 and	F 5	50		
	Use order 26.4k On 07/12/24 at 10:10 the electronic medica #8 and #9. Resident (PO) with a start date " Resident date of " Resident for, "Nowever, further revirevealed there was not the property of the province of the pro	AM, Surveyor #5 reviewed I record (EMR) for Resident #8 had a Physician Order of Nuccesser for, NJ ex order 26.4b1 #9 had a PO with a start				
	CFR(s): 483.10(e)(2) §483.10(e) Respect a The resident has a rig and dignity, including §483.10(e)(2) The rig possessions, includin as space permits, unl upon the rights or hea residents. This REQUIREMENT by: Complaint # NJ 1754	th to be treated with respect that to retain and use personal g furnishings, and clothing, ess to do so would infringe alth and safety of other is not met as evidenced	F 5	1. All NJ Ex Order 26.4(b)(1) ha been discharged from the facility.	8/20/24	
		n, interview, record review, nt facility documents, it was		2. All Justice involved Residents have	ve the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			1	C 29/2024	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077.	29/2024	
					5 JAY STREET			
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER			EWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION SHOULD DEFICIENCY)			(X5) COMPLETION DATE	
F 557	residents were treater respectful manner 11	acility failed to ensure that	F 5	557	potential to be affected by this deficient practice.	1		
	activities, community other residents, comr	ts from participating in group dining, intermingling with nunicating with visitors and This was cited as a ely jeopardizes the health			 3. All administrative staff will be reeducated on the importance of ensur that residents are treated in a dignified manner and respectful manner. 4. The Administrator/designee will audi 			
	and safety of the other residents that re resulted in an Immed	residents, as well as all eside in the facility which iate Jeopardy (IJ) situation.			residents a month x 4 months to ensur they are treated in a dignified and respectful manner. Audit findings will b shared with the QAPI committee month	e e		
	admitted to the facility	(Resident #1) was y and NJ ex order 26.4b1			x 4 months.			
	NJ ex order 26.4b1 when Resid	IJ situation was identified on dents #1, 2, 3, 4, 5, 6, 7, 8, 9, rved being NJ ex order 26.4b1 and						
	The facilities I S. F.							
	The facilities U.S. For situation on wexpoor 20-401 immediate jeopardy s	was informed of the IJ at 3:49 PM, that an						
	facility will take to pre occurring or recurring corrective action plan	was received on indicating the action the vent serious harm from The facility implemented a to remediate the deficient NJ Ex Order 26.4(b)(1) in the facility as of						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315236	B. WING			C 07/29/2024	
NAME OF PI	ROVIDER OR SUPPLIER	1 0.0200		STREET	ADDRESS, CITY, STATE, ZIP CODE	1 077	29/2024
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		65 JAY S	STREET RK, NJ 07103		
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F 557	Continued From pag	e 20	F 5	557			
	The facility will no lor	nger admit ^{NJ Ex Order 26.4(b)(1)}					
		ified the ^{NJ ex order 26.4b1} on-site mined the IJ was removed					
	The findings were as follows:						
	Surveyors on Federa services to Justice In 12/23/2016 S & C 16 Skilled Nursing Facili have autonomy and extent practicable res	CMS) updated Guideline to all Requirements for Providing volved individuals, revised in 21-ALL, documented ities must permit residents to choice to the maximum garding how they wish to live and receive care with the					
	dated 02/2024, inclue Explanation and Con "prior to or upon adm designee, or another will inform the reside responsibilities. 2. Explanation and the facility of the United States. resident has a right to dignity including the physical or chemical Self-determination. Tand the facility must resident's ehicle, incright to choose activity and control of the control of	npliance Guidelines" that hission, the social service designated staff member, and of the resident's rights and exercise of rights. The resident his or her rights as a vand as a citizen or resident 5. Respect and Dignity. The bet reated with respect and right to be free of any					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		315236	B. WING			07/	29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING AI	ND REHAB CENTER		65 JA	ET ADDRESS, CITY, STATE, ZIP CODE (STREET ARK, NJ 07103		
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F 557	outside the facility, a visitors. 7. Information resident has the right rights and of all the governing resident of during his or her state confidentially. The reprivacy and confidentially. The reprivacy and confidential records accommodations, moderated the records accommodations, accommoda	mmunity both inside and and the right to receive on and communication. The not to be informed of his or her rules and regulations conduct and responsibilities by in the facility. 8. Privacy and resident has a right to personal estated that has a right to personal notality of his or her personal estated treatment written and cation, personal care, visits, nily and resident groups." In the facility of his or her personal estated are treatment written and cation, personal care, visits, nily and resident groups." In the facility with order 26.4b1 In the facility with order 26.4b1	F	557			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING A	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 65 JAY STREET NEWARK, NJ 07103	CODE	0112012024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 557	Review of the reside (CP) dated CP NJ ex order The NJ ex order The CP NJ ex order A comprehensive M assessment tool that was not yet completed was not yet completed admission). Resident #1 NJ ex must sign at the time admission). According to the Andrough to the facility with the Review of the AA da NJ ex order 26.4	r a PO order dated der 26.4b1 ent's Individualized Care Plans which revealed that a succession whi	F	557			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 65 JAY STREET NEWARK, NJ 07103		11/23/2024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 557	Review of the phy that there were howeved ated New order 264101 to A comprehensive Further review of the Resident #1 did not Agreement. 3. According to the to the facility on NJ ex order 26410 NJ ex order 264	dent's CP dated CP order 26.4b1 The NJ ex order 26.4b1 Ver the Treatment cord (TAR) reflected an NJ ex order 26.4b1 MDS was not yet completed. The medical record revealed that of sign the facility Admission The AR, Resident #3 was admitted with diagnoses which Ab1 Cated CP order 26.4b1 The NJ ex order 26.4b1	F 5	557			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	315236					C 07/29/2024		
NAME OF PROVIDER OR SUPPLIER			B. WING _	STREET ADDRESS, CITY, STATE, ZIP CO		01129/2024		
SINAI POST ACUTE NURSING AND REHAB CENTER				65 JAY STREET NEWARK, NJ 07103				
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			(X5) COMPLETION DATE		
F 557	A review of the Care revealed no Care Pla supervision with Activate activities, of A comprehensive ME Further review of the Resident # 3 NJ ex 4. According to the A the facility NJ ex order 26.4 NJ ex order 26.4 NJ ex order 26.4 Review of the AA dat resident NJ ex order	Plan initiated on suscender 26.4b1 Plan initiated on suscender 26	F	DEFICIENCY 557	r)			
	Review of the resider comprehensive care did not include any in would address with Activities of daily	ex order 26.4b1. nt's individualized plan date initiated dicate focus areas that plan from NJ Ex Order 26.4(b)(1)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		(X3) DATE SURVEY COMPLETED		
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		315236	B. WING			07/	29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	D REHAB CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 5 JAY STREET IEWARK, NJ 07103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 557	Continued From page or Nexoscr254(5)(1)	e 25 Summary Report revealed a	F	557			
		dated NJ ex order 26.4, NJ ex order 26.4b1					
	Further review reveal	led that there were NJ ex order 26.461					
	·						
	Review of the MDS re MDS was not yet con	evealed a comprehensive npleted.					
	Further review of the Resident #4 NJ ex (medical record revealed that order 26.4b1					
		R, Resident #5 was admitted gnoses which included but					
	the resident was asse	resident was assessed as not having any or required [NJEX Order 25.4] or [NJEX Order 25.4] or [NJEX Order 25.4]					
	A review of the Care revealed no Care Pla supervision with Activ , activities, o	ns were initiated regarding vities of Daily Living					
		ciplinary progress note sled that Resident # 5					
		um Data Set revealed a was not yet completed.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 557 Continued From page 26 F 557 Further review of the medical record revealed that Resident #5 did not sign a facility Admission Agreement. 6. According to the AR; Resident # 6 was admitted to the facility on NJ ex order 26.4b1 with diagnoses which included but not limited to; NJ Ex Order 26.4(b)(1) Review of the AA dated . revealed that the resident was assessed and did not have any or required Review of the Care Plan initiated on revealed no Care Plans were initiated regarding supervision with ADLs, NJEX ORDER 25.4(D)(1) activities, or Review of the MDS revealed a comprehensive MDS was not yet completed. Further review of the medical record revealed that Resident #6 did not sign a facility Admission Agreement. 7. According to the AR, Resident # 7 was admitted to the facility on with diagnoses which included but not limited; to Review of the AA dated , revealed that the resident was assessed as not having any or required NJ Ex Order 26.4() or Review of a progress note dated revealed that Resident #7 was Review of the Care Plan initiated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 07/29/2024		
	315236		B. WING						
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE		<u> </u>		
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		65 JAY STR	EET				
				NEWARK,	NJ 07103				
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE		(X5) COMPLETION DATE		
F 557	Continued From page	e 27	F 5	557					
	revealed no Care Pla supervision with Activ NJEX OTION 253-(ID) activities, of	ans were initiated regarding vities of Daily Living, or ^{মোহ্মতালেহত্যবঢ়ায়}							
	Review of the MDS re MDS was not yet con	evealed a comprehensive npleted.							
	Further review of the Resident #7 did not s Agreement.								
	8. According to the A admitted to the facility diagnoses which include NJ Ex Order 26.4	y on ^{NJ ex order 26.4b1} with uded but not limited to;							
	Review of the AA dat revealed that the resi having any NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)	ident was assessed as not							
		Plan initiated on Note of the Plan i							
	Review of a progress revealed that Reside								
	Review of the MDS re MDS was not yet con	evealed a comprehensive npleted.							
		medical record revealed that sign a facility Admission							
	9. According to the A	R, Resident #9 was admitted							

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			(X3) DATE SURVEY COMPLETED		
315236					C 07/29/2024		
	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIF 65 JAY STREET NEWARK, NJ 07103	P CODE	0112312024		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE AI CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
Review of the AA daresident was assess and required no however on 07/11/24 and Surveyor #2 obstroom NJ ex order A review of the CP daresident required NJ ex order 26.4(b)(1) for daily living (ADLs). The resident was NJ unless for NJ Ex Order 26.4(b)(1) and documentation on the from NJ Ex Order 26.4(b)(1). Review of the progress of the physical that there were NJ ex order 26.4(b) (1).	degroses which included but J Ex Order 26.4(b)(1) ted Seed as having no NUES Order 26.4(b)(1), 4 at 10:43 AM, Surveyor #1 served the resident in the 26.4b1 deted Seed as having no NUES Order 26.4(b)(1), 5 at 10:43 AM, Surveyor #1 served the resident in the 26.4b1 deted Seed or the use of id not address that the Ex Order 26.4(b)(1) from the NUES Order 26.4(b)(1) from the NUES Order 26.4(b)(1) the room and NUES Order 26.4(b)(1) by the determinent of the transport of the transp	F	557				
	SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From page to the facility with dia was not limited to N. Review of the AA da resident was assess and required no however on 07/11/2 and Surveyor #2 obs room NJ ex order A review of the CP of a CP was not impler a CP was not impler resident required NJ NJ EX Order 26.4(b)(1) for daily living (ADLs), the resident was NJ unless for NJ EX Order 26.4(b)(1) and documentation on the from NJ EX Order NJ EX Order 26.4(b)(1). Review of the progre NJ EX Order 26.4(b)(1). Review of the progre NJ EX Order 26.4(b)(1). Review of the physic that there were NJ however dated NJ ex order 26.4(b) There were no cons regarding the use of	A review of the AA dated and required no mover on 07/11/24 at 10:43 AM, Surveyor #1 and Surveyor #2 observed the resident in the room NJ ex order 26.4(b)(1) A review of the CP dated a CP was not implemented for the use of the resident required NJ Ex Order 26.4(b)(1) from the NJ Ex Order 26.4(b)(1) from the CP daily living (ADLs). The CP did not address that the resident was NJ Ex Order 26.4(b)(1) the room unless for NJ Ex Order 26.4(b)(1) and there was no documentation on the CP to address from NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Review of the CP dated NJ Ex Order 26.4(b)(1) from the NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) from the NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) the room unless for NJ Ex Order 26.4(b)(1) and there was no documentation on the CP to address from NJ Ex Order 26.4(b)(1) and there was no documentation on the CP to address from NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Review of the progress admission note dated NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).	ROVIDER OR SUPPLIER ST ACUTE NURSING AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 to the facility with diagnoses which included but was not limited to NJ Ex Order 26.4(b)(1) Review of the AA dated and required no saving no saving no and required no saving no	ROVIDER OR SUPPLIER STACUTE NURSING AND REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 28 to the facility with diagnoses which included but was not limited to INJ EX Order 26.4(b)(1) Review of the AA dated and required no Indian Surveyor #2 observed the resident in the room INJ ex order 26.4b1 A review of the CP dated Indian Surveyor #2 observed the resident in the room INJ ex order 26.4(b)(1) from the INJ EX Order 26.4(b)(1) and there was no documentation on the CP to address that the resident was NJ EX Order 26.4(b)(1) and there was no documentation on the CP to address from INJ EX Order 26.4(b)(1) Review of the progress admission note dated Indian Surveyor Ind	TOURDER OR SUPPLIER 315236 315236 315236 315236 315236 STREET ADDRESS, CITY, STATE, ZIP CODE SLAY STREET NEWARK, NJ 07103 SUMMARY STATEMENT OF DESCIGNOISS (EACH DEPCEMBRY MUST BE PRECEDED BY PLUL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 to the facility with diagnoses which included but was not limited to NJ EX Order 26.4(b)(1) Review of the AA dated The CP did not address that the resident was some to implemented for the use of summer of the complete o		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	AND REHAB CENTER	•	STREET ADDRESS, CITY, STATE, ZIP OF 65 JAY STREET NEWARK, NJ 07103	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 557	Resident #9 did not Agreement. 10. According to the admitted on included but not linded but not	the medical record revealed that of sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facility Admission The AR, Resident #10 was and had diagnoses which mited to: NJ ex order 26.4b1 This sign a facil	F 5	557				

AND PLAN OF CORRECTION IDENTIFICATION NU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(.	(X3) DATE SURVEY COMPLETED		
		315236	B. WING			C 07/29/2024		
NAME OF PROVIDER OR SUPPLIER SINAI POST ACUTE NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP OF 65 JAY STREET NEWARK, NJ 07103	CODE	01720/2027		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE		
F 557	Review the AA darresident was NJ 6 observed by Surve 07/11/24 at 10:44 A review of the CF CP was not implet The CP did not ad NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b) for LEX ORDER for LEX ORD	ted Wexorder 26.4b1 ted New order 26.4b1 however Resident #11 was eyor #1 and Surveyor #2 on AM, NJ ex order 26.4b1 condition of the use of NJEX Order 26.4(b)(1) dress that the resident required (1) from the NJ Ex Order 26.4(b)(1) dress that the resident NJEX Order 26.4(b)(1) dress that the resident NJEX Order 26.4(b)(1) dress that the resident NJEX Order 26.4(b) (1) dress that the resident NJEX Order 26.4(b) (1) dress that the resident NJEX Order 26.4(b) (1) dress that the resident NJEX ORDER (1) dress that the resi	F5	557				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 07/29/2024	
	315236					
NAME OF PROVIDER OR SUPPLIER SINAI POST ACUTE NURSING AND	REHAB CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 65 JAY STREET NEWARK, NJ 07103	E	,	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
that the Second NJ ex order 26.4bd that the Second NJ ex order NJ ex	She stated rder 26.4b1 She stated that the CO also J ex order 26.4b1 5 AM, Surveyor #1 and #2 and Data Set Coordinator at the eleven (11) had led the surveyors are all 11 stated until day 14 of provided the surveyors are all 11 stated or and practical Nurse (LPN#1) resident at the facility. LPN #1 6 (six) stated or an agency and that riking at the facility. LPN #1 6 (six) stated or esidents NJ ex order 26.4b1 explain that he was not string in that he was not string in the stated order 26.4(b)(1) the residents NJ ex order 26.4b1 explain that he was not string in that he was not string in that he was not string in that he was not as a residents from other on his unit.	F 5	57			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 557 Continued From page 32 F 557 NJ ex order 26.4b1 On 07/11/24 at 10:30 AM, resident interviews were attempted by Surveyor #1 and #2, and was prohibited by the NJ Ex Order 26.4(b)(1). On 07/11/2024 at 10:30 AM, Surveyor #1 and Surveyor #2 interviewed a gentleman outside in the hallway who identified himself as a contracted U.S. FOIA (b) (6) NJ Ex Order 26.4(b)(1) stated that the surveyors were not allowed to enter the rooms and would not allow the surveyors to interview the west on the 4 (four) West Unit (Resident #2, 5, 6, 8, 9, and 11). The explained to Surveyor #1 and Surveyor #2 that the NJ ex order 26.4b1 He stated that all JIRs NJ ex order 26.4b1 , and NJ ex order 26.4b1 He explained that wearing of ankle restraints depended on the resident's medical condition. He stated that all residents could not attend facility activities and could not intermingle with other residents and could only talk amongst residents. He stated that the other He stated that the NJ ex order 26.4b1 . He stated that NJ ex order 26.4b1 On 07/11/2024 at 10:42 AM, Surveyor #1 observed Resident #5 and #6 from the hallway NJ ex order 26.4b1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	()	(X3) DATE SURVEY COMPLETED		
		315236	B. WING _			C 07/29/2024	
NAME OF PROVIDER OR SUPPLIER SINAI POST ACUTE NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 65 JAY STREET NEWARK, NJ 07103	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 557	NJ ex order 26.4 NJ ex order 26.4 NJ ex order 26.4 On 07/11/2024 at 11: Surveyor #2 toured the surveyor interviewed there were three (3) #1, #4 and #10). AUS FOIA (B) (6) interviewed and state residents required apoffice or judge to have. On 07/11/24 at 11:05 Surveyor #2 were giv. US FOIA (b)(6) to in was observed in bed the Resident #4 NJ ex order 26.4 The surveyor Resident #4 NJ ex order 26.4 resident stated that for	allway Resident #8 and #9 b1 b1 . 00 AM, Surveyor #1 and he NJ ex order 26.4b1 . The LPN #2 who stated that NJ ex order 26.4b1 (Resident) was ed that all justice involved oproval by the U.S Attorney's re interviews or visitation. AAM, Surveyor #1 and ven permission from the terview Resident #4 who . The surveyor observed that ex order 26.4b1 in the room indicated that order 26.4b1 ors observed the Nexoder 26.4b1 stated that they were in the b1. The	F	557			
	Resident #4 was NJ ex order 2	stated that otherwise there 26.4b1					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING			1	29/2024
NAME OF PROVIDER OR SUPPLIER SINAI POST ACUTE NURSING AND REHAB CENTER			l	6	TREET ADDRESS, CITY, STATE, ZIP CODE 5 JAY STREET IEWARK, NJ 07103	011	EJI EUL T
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	E ATE	(X5) COMPLETION DATE	
F 557	Surveyor #2 were giv US FOIA (b)(6) to in was NJ ex order 26.4b1 he/she was admitted diagnoses of NJ ex that they received me to pick his/her own m honored food prefere NJ ex order 26.4 The resid On 07/11/2024 at 11: Surveyor #2 interview Unit Manager (LPN/L Resident #3 resided diagnoses of NJ ex resident as a NJ ex order 26.4 She stated activities NJ ex order 26.4 there was NJ ex O LTC residents. LPN/L #7 also resided on the She state On 07/11/2024 at 11: Surveyor #2 interview On 07/11/2024 at 11: Surveyor #2 interview	ren permission from the terview Resident #1, who . The resident stated that to the facility with the order 26.4b1 Resident #1 stated eals in the room but was able heals and that the facility ences. The resident stated but stated that NJ ex order 26.4b1 20 AM, Surveyor #1 and wed Licensed Practical Nurse JM #1) who stated that on the floor and had the order 26.4b1 She also identified the stated that Resident stated that Resident to the floor and had a stated that Resident was not allowed to the floor and had a stated that Resident #7's as Resident #7's stated that Resident #3. 35 AM, Surveyor #1 and wed the US FOIA (B) (6) no stated that she was	F	557			

admitted to the facility that NJ ex order 26.4b1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 557 Continued From page 35 F 557 NJ ex order 26.4b1. She stated that she was told not to complete an activities assessment on admission. She stated that she provided the residents with a basket of puzzles and cards on admission, however the residents NJ exo On 07/11/24 at 11:42 AM, Surveyor #1 and Surveyor #2 interviewed the US FOIA (B) (6) who stated that she had been employed by the facility for about NJ Ex Order 28.4(b She explained what her role was when residents were admitted to the facility and stated that during the admission process, she performed a with the resident. Explained the process of completing an advanced directive, discharge planning and held Care Plan meetings. She stated that when the were admitted to the facility she provided them with a list of resident rights, advanced directives, billing information and pain management. She stated that based on federal regulations in nursing homes keeping a resident NJ Ex Order 26.4(b)(and not being NJ Ex Order 26.4(b)(1) was a form of NJ Ex Order 26.4(b)(1). She stated that the JEX Order 26.4 for residents were being and that that was against the On 07/11/24 at 12:20 PM, during an interview with stated that NJ ex order 26.4b1 Surveyor # 1 the Further, he confirmed that being served food restriction of with plastic and paper products and requiring during activities of daily living were all violations of federal regulations for Long-Term Care. He concluded that if a long-term care resident was not able to NJ Ex Order 26.4(b)(1 then that would be a form of

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		315236	B. WING _			C 07/29/2024
	ROVIDER OR SUPPLIER	ID REHAB CENTER		STREET ADDRESS, CITY, STATE, Z 65 JAY STREET NEWARK, NJ 07103	GITEGIEGE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCED		
F 557	Resident #4 and Resobservation revealed observation revealed observed residents # the NJ ex order 2 identified a beds. The residents and the surveyor from enterir interviewing the residents and the surveyor from enterir interviewed Licensed #2), who stated she medication and the NJ ex order 26.4 would NJ Ex Order 26.4 w	Resident #1, sident #10's rooms. Further that there were Surveyor # 4 44 and #10 from the hallway, 6.4b1 s Resident #4 and #10 in the NJ ex order 26.4(b)(1) the ng the rooms and from dents. 18 AM, Surveyor #4 19 Practical Nurse #2 (LPN could give the residents would identify the nand the stated that there were 4(b)(1), and one would care and staff was not order 26.4(b)(1). She e and all the staff are course. 19 AM during an interview of #5, Unit Manager #3 19 Dex order 26.4b1. The could give the residents would care and staff was not order 26.4(b)(1). She e and all the staff are course. 19 AM during an interview of #5, Unit Manager #3 19 Dex order 26.4b1. The could give the received their meals. Lastly, she only come out of their rooms 6.4b1. 19 AM, Surveyor #4 19 AM, Surveyor	F	557		
	that they were aware	e there are NUEX OTHER 25.4(0) at the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()		NSTRUCTION	(X3) DATE COMP	SURVEY
		315236	B. WING _			1	C 29/2024
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2024
				65 JA	Y STREET		
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		NEW	ARK, NJ 07103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 557	Continued From page	∍ 37	F 5	557			
	facility and the NJ ex order 26.4b1						
		34 AM, Surveyor #1 and					
		ved the USFOIA (B) (C) who stated					
	that the facility could	ver after he received the					
	· ·	and Medicaid Services					
		16-21-ALL, with a revised					
		understood that it was					
		ation NJ ex order 26.4b1					
	He stated th	nat he called the nursing					
		inform them to stop sending					
	_	, but they just kept sending					
		he did not refuse to admit					
	the residents to the fa						
		re else to go. He then stated					
		cility that was imposing these needs, it was the NJ ex order 26.451					
		osing them. He added that					
		e that the wexer were being					
		the facility than the regular					
		that it was not the facilities					
	_	however he felt that the					
	NJ ex order 26.4b	vas a strong					
		hat he was between the					
	Department of Health	and the Nextree					
		AM, Surveyors #3 and #5					
		terviews with Resident #8					
		by the US FOIA (B) (6) that					
		ermitted but the surveyors					
		through the doorway of					
	-	r #5 observed Resident #8's					
		n the bedside table, the served on a disposable tray					
		os, and utensils. Resident					
	#8 was observed in t						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315236	B. WING			l	29/2024
	ROVIDER OR SUPPLIER	ID REHAB CENTER		65	TREET ADDRESS, CITY, STATE, ZIP CODE 5 JAY STREET EWARK, NJ 07103	<u> </u>	23/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 557	On 07/12/24 at 09:44 #5 interviewed the was were served all plates, utensils and of meals checked by the serving. The shower schedule was the evening and the shower room with the On the same date at fourth floor, Surveyo and Resident # 6 frowere in the room. The guards. No resident door placard. Resident who is the nurse LPN #1 stated the was long to the main dining area. On the same date at interviewed an unsait that they had no interviewed the line was long to the same date at interviewed an unsait that they had no interviewed the line was long to the same date at interviewed an unsait that they had no interviewed the line was long to the same date at interviewed an unsait that they had no interviewed the line was long to the same date at interviewed an unsait that they had no interviewed the line was long to the same date at interviewed an unsait that they had no interviewed the line was long to the line was long to the was long to the was long to the line	dent #9 was observed in bed b1 O AM, Surveyors #3, #4, and US FOIA (B) (6) who stated the their meals on disposable cups as well as having their end of further stated the structure of furth	F	557			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ С 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 557 Continued From page 39 F 557 Surveyor #2 interviewed who stated that residents being NJ Ex Order 28.4(b)(1) their room, other residents, and not being able to attend activities or eat in the main dining rooms were all a form of NEX OTHER 25.4(D)(1) however it was not the that was enforcing this on the NJ ex order 26.4b1 was the NJ ex order 26.4b1 On 07/12/24 at 1:24 PM, Surveyors #1, #2, #3, #4, and #5 conducted a phone interview with the US FOIA (B) (6) who stated that he had been on vacation when the 11 Wexage were admitted to the facility. He stated he was not aware that the were WEX Order 26.4(b)(1) their rooms or that they 11 with NJ Ex Order 26.4(b)(1). The further stated that he did not write physician orders for NJEX Order 25.4(D) for any of the 11 On 07/12/24 at 3:40 PM, Surveyors #2, #3, #4 and #5 met with the USFOIA (B) (6), and and were notified of the IJ and were provided with the IJ template. On 07/15/2024 at 8:45 AM, while on the , Surveyor # 3 observed Resident # 4 from the hallway. The NJEXOTOR would not allow the surveyor to enter the room. At that time, Surveyor #3 observed a NJ ex order 26.4b1 NJ ex order 28.4b1 Was observed within the room. Also at that time, Surveyor #3 observed Resident #10 in bed. A NJ ex order 26.4b1 Also, NJ ex order 26.4b1 in that room. On the same date at 8:51 AM, while on the , Surveyor # 3 observed Resident # 6 and Resident # 5 in their rooms. They had

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION NG	1, ,	E SURVEY PLETED
		315236	B. WING			C / 29/2024
NAME OF P	ROVIDER OR SUPPLIER	0.0200	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	07	12912024
	ST ACUTE NURSING AN	D REHAB CENTER		65 JAY STREET NEWARK, NJ 07103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIDE DEFICIENCY)		BE	(X5) COMPLETION DATE
F 561	interviewed the with or heard from the Health (NJDOH), Cer Medicaid (CMS), and that he could not subtracted the deficiencies because released into the fremoved from the factor of the Surveyor #2 and involved residents we still VJ ex order 26.4b1. NJAC 8:39-4.1 Self-Determination	who stated until he met who stated until he [contracted company] with a removal plan for any of use the was order 20.451 could not acility and would have to be willity. AM during an interview with who stated until he was stated and was stated until he was stated un		557		8/20/24
SS=K	§483.10(f) Self-deterr The resident has the promote and facilitate through support of re- not limited to the right (1) through (11) of thi §483.10(f)(1) The res activities, schedules (waking times), health care services consists assessments, and pla applicable provisions §483.10(f)(2) The res	mination. right to and the facility must resident self-determination sident choice, including but ts specified in paragraphs (f) s section. ident has a right to choose fincluding sleeping and care and providers of health ent with his or her interests, an of care and other of this part. ident has a right to make s of his or her life in the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE S	
		315236	B. WING _			07/2	29/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY	', STATE, ZIP CODE	1 0112	10/2024
				65 JAY STREET			
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	÷ 41	F 5	61			
	with members of the community activities I facility.	ident has a right to interact community and participate in both inside and outside the					
	religious, and commu interfere with the right facility.	ident has a right to ctivities, including social, nity activities that do not ts of other residents in the is not met as evidenced					
	Complaint # NJ 1754			1. NJ ex orde	er 26.4b1		
	and review of pertined determined that the fa facilitate 11 of 11 NJ (Resident #1, 2,	3, 4, 5, 6, 7, 8, 9, 10, and		potential to be a practice.	volved Residents have to		
	aspects of their life ar activities and 3) intera community both insid The failure to promote	heir own choices regarding and care; 2) participate in act with members of the e and outside the facility.		that resident righ	native starr will be the importance of ensur hts are promoted and ding self-determination.		
	NJ Ex Order 26.4(b)(1) ha	d the NJ ex order 26.4b1		residents a mon residents are be	rator/designee will audi ith x 4 months to ensure sing afforded their right	e of	
	interviewed the US F stated that she was n US FOIA (B) (6) facility. The the facility's administration of the state of the facility's administration of the state	otified by the facility's that were entering the ed that the			on. Audit findings will be QAPI committee month		
		from the US FOIA (B) (6) to interact with other					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		315236	B. WING _				29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING ANI	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 65 JAY STREET NEWARK, NJ 07103	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
F 561	that she was informed Team and the Team and the World Inches would not be atterned would	AM, Surveyor #1 OIA (B) (6) who stated by the Interdisciplinary hat no activity assessment for the because the ending any activities. AM, Surveyor #3 and #5 ager (UM) #3 who stated rder 26.4b1. UM3 stated ne out of their rooms for rder 26.4b1 as informed of the (IJ) situation on of the choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions ent has a right to interact community and participate in both inside and outside the vent serious harm from the remediate the deficient NJ ex order 26.4b1 NJ ex order 26.4b1	F	561			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		315236	B. WING _			C 07/29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING AI	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 65 JAY STREET NEWARK, NJ 07103	0.120.202	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT	DATE
F 561	Continued From pag	ge 43	F 5	561		
	on NJ ex order 25.4b1 as of NJ ex order 25.4b1 .	rified the removal plan on-site rmined the IJ was New order 26-451				
	The findings were as	s follows:				
	Reference: The Centers for Medicare and Medicaid Services (CMS) Updated Guideline to Surveyors on Federal Requirements for Providing Services to Justice Involved Individuals, revised 12/23/16, S&C 16-21 ALL, documented that Skilled Nursing Facilities must permit residents to have autonomy and choice to the maximum extent practicable regarding how they wish to live their everyday lives and receive care with the same rights as nursing home residents.					
	"Resident Rights" in would be treated equiver sex, ethnicity, religion or mental disability, sexual orientation, of expression. The resident has a right the community and pactivities both inside right to receive visite subject to the resident when applicablerigroupsthe right for accommodations, mecommunications, pe	dicated 02/2024 and titled, dicated that "all residents ually regardless of age, race, on, culture, language, physical socioeconomic status, sex, or gender identity or ident has a right to be treated pect including being free from mical restraints imposed for ipline or convenience. The to interact with members of participate in community and outside the facility the pers of his or her own choosing ont's right to deny visitation ght to participate in family or personal privacy includes edical treatment, telephone resonal care, visits and ond residents groups."				
	Review of a facility p	policy titled "Care Plan" with a				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		315236	B. WING _			l	C 29/2024
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	<u> </u>	25/2024
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		65 JAY STREET			
				NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 561	Continued From page	e 44	F 5	561			
	that, "It is the policy of admitted to the facility person-centered care their needs in a timel Review of a facility personams" with a reviewaled under, "Poli Implementation" that are designed to enco	e plans that provide for all y manner." olicy titled, "Activity ised date of February 2024					
	resident's needs." On 07/11/24 at 11:05 were given permission to interview Restated they could NJ NJ ex order 26.4 NJ ex order 26.4 Resid there was phone. The surveyors attemptone.	AM, Surveyor #1 and #2 on from the NJ Ex Order 26.4(b)(1) esident #4. Resident #4 ex order 26.4b1 b1 and b1 ent #4 stated that otherwise when speaking on the					
	but were denied by the The survey reviewed	the medical records.					
		dmission Record (AR), nitted with diagnoses which b1					
		ion progress note dated revealed Resident #1					
	2. According to the A	R, Resident #2 was admitted					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		315236	B. WING			C 7/ 29/2024	
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CO 65 JAY STREET NEWARK, NJ 07103		11/25/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 561	3. According to the with diagnoses while Review of a progres revealed Resident 4. According to the with diagnoses while Resident #4 NJ expendence with diagnoses while Review of an Interest dated Newsons NJ expenses NJ Review of a Social Newsons NJ expenses NJ at 9:45 Platert and oriented NJ Status (BIMS) scorthe resident's NJ expenses NJ e	which included but 26.4b1 AR, Resident #3 was admitted ch included but 3 ex order 26.4b1 ass note dated 4 ex order 26.4b1 AR, Resident #4 was admitted ch NJ ex order 26.4b1 AR, Resident #4 was admitted ch NJ ex order 26.4b1 AR, Resident #5 was admitted ex order 26.4b1 AR, Resident #5 was admitted ex order 26.4b1 disciplinary progress note excelled Resident #5 was noses which NJ ex order 26.4b1 Service progress note dated M, revealed Resident #6 was with a Brief Interview for Mental te of 4 at of 15 indicating that	F 56				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		315236	B. WING			C 7/29/2024
	ROVIDER OR SUPPLIER	AND REHAB CENTER	,	STREET ADDRESS, CITY, STATE, ZIP C 65 JAY STREET NEWARK, NJ 07103		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	*	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 561	8. According to the admitted with diagolimited to; NJ ex Review of an Admitted with diagolimited with	nission summary note dated AM, revealed Resident #7		561		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		315236	B. WING		C 07/29/2024
NAME OF PR	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE	07/29/2024
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		65 JAY STREET NEWARK, NJ 07103	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE COMPLETION
F 561	Continued From page	e 47	F 5	61	
	Review of a progress PM, Resident #11 wa	note date ^{NJ ex order 25.4b1} at 4:08 s NJ ex order 26.4b1			
	for Resident #1 through	dualized Care Plans (ICP) gh #11 revealed no CPs sing the resident's choices			
	significant to the residue medical record reveal #11 NJ ex order 26	dents. Further review of the led that Resident #1 through			
	. •	unavailable for review.			
F 603 SS=K	NJAC 8:39-27.1(a) Free from Involuntary CFR(s): 483.12(a)(1)	Seclusion	F 6	03	8/20/24
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to			
	§483.12(a) The facilit	y must-			
	physical abuse, corpo involuntary seclusion;				
	Complaint # NJ 1754 Based on observation			1. All NJ Ex Order 26.4(b)(1) been discharged from the facility.	have

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		315236	B. WING		0.	C 7/ 29/2024	
	ROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 65 JAY STREET NEWARK, NJ 07103		112312024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 603	facility documentation facility failed to ensure facility failed to ensure facility failed to ensure failed facility failed to ensure failed facility facili	ords and other pertinent in it was determined that the re that 11 of 11 (Resident #1, 2, 3, 4, 5, 1) NJ ex order 26.4b1 (Resident #1, 2, 3, 4, 5, 1) NJ ex order 26.4b1 (Resident #1, 2, 3, 4, 5, 1) NJ ex order 26.4b1 (Resident #1, 2, 3, 4, 5, 1) NJ ex order 26.4b1 (Resident #1, 2, 3, 4, 5, 6, 7, 8, 1) NJ ex order 26.4b1 (NJ ex order 26.4b1) (NJ	F 6	2. All Justice involved Reside potential to be affected by the practice. 3. All administrative staff will reeducated on the important that residents are free from it seclusion. 4. The Administrator/designeresidents a month x 4 month they are free from involuntar Audit findings will be shared committee monthly x 4 month.	l be ce of ensuring involuntary ee will audit 5 as to ensure ry seclusion. with the QAPI		
	Substandard Quality of Federal Regulatio	d of the IJ situation on PM which also constituted of Care (SQC) for 42 Code ns (CFR) 483.12(a)(1). The verbal, mental, sexual, or oral punishment, or					
	7/29/24 at 9:59 AM, facility will take to procurring or recurring	val plan was received on indicating the action the event serious harm from g. The facility implemented a n to remediate the deficient					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103	•	01720/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 603	The survey team voon 7/29/24, and de as of 7/26/24. The findings are as Reference: The Ce Medicaid Services Surveyors on Fedeservices to Justice 12/23/2016, S & C Skilled Nursing Fachave autonomy an extent practicable in their everyday lives same rights as nursured their everyday lives same rights as nursured to the sex, ethnicity, religior mental disability sexual orientation, expression. The rewith dignity and resured the purposes of dis resident has a right the community and activities both insiding to receive visi subject to the resident value of the purpose of the receive visi subject to the resident value of the receive visi subject to the resident value of the purpose of the receive visi subject to the resident value of the resident value of the value of valu	All NJ Ex Order 26.4(b)(1) om the facility as of NJ Ex Order 26.4(b)(1) onger admit NJ Ex Order 26.4(b)(1) erified the removal plan on-site termined the IJ was removed	F6	003			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 315236 R WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 603 Continued From page 50 F 603 accommodations, medical treatment, telephone communications, personal care, visits and meetings of family and residents groups." On 07/11/2024 at 09:00 AM, Surveyor #1 and Surveyor #2 interviewed the US FOIA (B) (6) who stated that she was notified by the JS FOIA (B) (6) that entering the facility. She stated that the facilities instructed the US FOIA (B) (6) not to mix the with other residents and that they needed to be NJ Ex Order 26.4(b)(1). She stated would be NJ Ex Order 26.4() by that the and NJ ex order 26.4b1 She stated that the also instructed the facility not to mix or intermingle the with other residents in the facility, no community activities or outside visitation. On 07/11/2024 at 10:20 AM, Surveyor #1 and Surveyor #2 toured the NJ ex or and interviewed Licensed Practical Nurse (LPN#1) who stated that he worked for an agency and that working at the facility. LPN #1 it was stated that there were 6 (six) residing on his unit (Resident #2, #5, #6, #8, #9, and #11). He stated that there were NJ Ex Order 26.4(b)(1) the residents and that the residents NJ ex order . He continued to explain that he was not sure what the residents' NJ ex order 26.4b1 and was not aware of any had. He also added that he was not aware of any complaints about these residents from other residents that resided on his unit. On 07/11/2024 at 10:25 AM, Surveyor #1 observed the from the hallway. Residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		315236	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	313230	B. WING	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	07/	29/2024
SINAI PO	ST ACUTE NURSING AN	ID REHAB CENTER			AY STREET VARK, NJ 07103		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 603	#2, #5, #6, #8, #9 an were obs NJ ex order 26.4 On 07/11/2024 at 10 Surveyor #2 interview the hallway who ider U.S. FOIA (b) (6) NJ Ex Order 26.4 that the surveyors we rooms and wou interview the explained to twere at the facility for stated that all and all he explained that the depended on the resistated that all residents and could be residents. He stated or any other reason with the other rooms with the other row visitation of anyone residents. On 07/11/2024 at 10	d #11, that resided on the erved in their rooms being b1 :30 AM, Surveyor #1 and wed a gentleman outside in nitified himself as a contracted of the light of the	F	603			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			07/:	29/2024	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 65 JAY STREET NEWARK, NJ 07103	ODE:	, , , , , , , , , , , , , , , , , , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 603	guarded to the roo NJ ex order 26 On 07/11/2024 at a Surveyor #2 toure surveyor interview there were three (3 #1, #4 and #10). On 07/11/2024 at a Surveyor #2 were detention officer to was observed in but that Resident #4 The The resident NJ ex The surveyor #2 were detention officer to was observed in but that Resident #4 The The surveyor #2 were detention guard to NJ ex order 26.4 On 07/11/2024 at a Surveyor #2 were detention guard to NJ ex order 26.4	t #8 and #9 from the hall, being m by <mark>NJ ex order 26.4b1</mark> and	F	503				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 315236 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 603 Continued From page 53 F 603 diagnoses of NJ Ex Order 26.4(b)(and and The resident indicated that they NJ ex order 26.4b1 . Resident #4 stated that they received meals in the room but was able to pick their own meals and that the facility honored food preferences. The resident stated resident stated that this NJ ex order 26.4b1 On 07/11/2024 at 11:20 AM, Surveyor #1 and Surveyor #2 interviewed Licensed Practical Nurse Unit Manager (LPN/UM #1) who stated that and had the Resident #3 resided on the diagnoses of NJ ex order 26.4b1 She also identified the resident as a NJ ex order 28.4b1 She stated that Resident #3 NJ ex order 26.4b1 She stated that the resident had activities in the room but NJ ex order 26.4b1 because there was NJ Ex Order 26.4(b)(1) with NJ ex ord LTC residents. LPN/UM #1 stated that Resident #7 also resided on the and had a history . She stated that Resident #7's restrictions were the same for Resident #3. On 07/11/2024 at 11:35 AM, Surveyor #1 and Surveyor #2 interviewed the US FOIA (B) (6 who stated that she was informed by the US FOIA (B) (6) that when the admitted to the facility that she was to have no interactions with them. She stated that she was told not to complete an activities assessment on admission and that resident were not to attend

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			1	C 29/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				65	5 JAY STREET			
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		N	EWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 603	Continued From page	e 54	F 6	503				
	she provided the puzzles and cards on On 07/11/2024 at 11:	42 AM, Surveyor #1 and						
	who sta employed by the facil She explained what h	ner role was when residents						
		facility and stated that during s, she performed a social with the resident. She						
	explained the process	s of completing an advanced lanning and held care plan						
	meetings. She stated	that when the NJ exc were						
	list of resident rights,	y she provided them with a advanced directives, billing						
		management. She stated regulations in nursing						
	homes keeping a res	ident in the room Section 26.40 Corder 26.4(b)(1) was a (b)(1). She stated that the						
		eing isolated for safety						
	regulations.	·						
	#4, and Surveyor #5 observed NJ ex ord near Resident #1, Re	sident #4, and Resident						
	there were NJ ex order 20 rooms. Surveyor # 4 #10 from the hallway	observation revealed that 5.451 standing inside the observed Residents #4 and and were observed to be						
		s and the terring the rooms and from ents.						
	On 07/12/2024 at 9:1	8 am, Surveyor #4						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 315236 R WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 603 Continued From page 55 F 603 interviewed Licensed Practical Nurse #2 (LPN #2), who stated she could give the residents would identify the medication and the NJ ex order 26.4b1 and the would Wex order 25.4(b)(1 give the medication to the residents. LPN #2 further stated that there were always Nex order 25.4(b)(1) present, and Nex order 25.4(b)(1) would the nursing care and staff were not allowed to NJ Ex Order 26.4(b)(1) further stated that she and all the staff were supervised by the On 07/12/2024 at 9:30 AM, Surveyor #4 interviewed an unsampled resident who stated that they are aware there are at the do not NJ Ex Order 26.4(b)(1 facility and the and do not NJ Ex Order 26.4(b)(1) with other residents. On 07/12/2024 at 09:34 AM, Surveyor #1 and Surveyor #2 interviewed the who stated that the facility could accommodate the medical needs, however after he received the Centers for Medicare and Medicaid Services (CMS) memo S & C: 16-21-ALL, with a revised date NJ ex order 26.4b1, he understood that it was against federal regulation to . He stated that he called the nursing home in New York to inform them to stop sending to the facility, but they just kept sending them. He stated that he did not refuse to admit the resident to the facility because the residents NJ ex order 26.4b1. He then stated that it was not the facility that was imposing the , it was the restrictions on the that was imposing them. He added that the facility was aware that the were being treated differently by the facility than the regular facility residents and that it was not the facilities

	(X3) DATE SURVEY COMPLETED	
	С	
315236 B. WING 07/29/2	9/2024	
NAME OF PROVIDER OR SUPPLIER SINAI POST ACUTE NURSING AND REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 603 Continued From page 56 standard of practice, however he felt that the NJ ex order 26.4b1 and that he was between the Department of Health and the Surveyor #4, and Surveyor #5 interviewed the Surveyor #4, and Surveyor #5 interviewed the Were served all their meals on disposable plates, utensils, and cups, and the The UM further stated that the shower schedule was Tuesday and Thursday in the evening, and the NJ ex order 26.4b1 On 07/12/2024 at 09.40 AM, Surveyor #3 and Surveyor #5 attempted resident interviews with Resident #8 and #9 but were told by the that interviews were not permitted but we could observe the that interviews were not permitted but we could observe the the resident from some surveyor #5 observed Resident #8's breakfast meal tray on the bedside table, the resident's meal was served on a disposable tray, plates, cups, and utensils. Resident #8 was observed in the room in a wheelchair with an NJ ex order 26.4b1 by a NJ ex order 26.4b1 Resident #9 was observed in bed with an NJ ex order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #5 interviewed LPN #1 who was the nurse for both Resident #8 and #9. LPN #1 stated the SNJ Ex Order 26.4b1 Lex Order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #5 interviewed LPN #1 who was the nurse for both Resident #8 and #9. LPN #1 stated the Lex Order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #5 interviewed LPN #1 who was the nurse for both Resident #8 and #9. LPN #1 stated the Lex Order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #5 interviewed LPN #1 who was the nurse for both Resident #8 and #9. LPN #1 stated the Lex Order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #5 interviewed LPN #1 stated the Lex Order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #3 interviewed LPN #1 stated the Lex Order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #3 interviewed LPN #1 stated the Lex Order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #3 interviewed LPN #1 stated the Lex Order 26.4b1 On 07/12/2024 at 09.45 AM, Surveyor #3 interviewed LPN #1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 603 Continued From page 57 F 603 On 07/12/2024 at 12:15 PM, Surveyor #1 and Surveyor #2 interviewed the who stated that residents being NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) other residents, and not being able to attend activities or eat in the main dining rooms were all a form of NIEX OTDER 25.4(b)(1) however it was not section that was enforcing that on the residents, it was the US FOIA (B) (6 1. According to the Admission Record (AR), Resident #1 was admitted to the facility with diagnoses which NJ ex order 26.4b1 According to the Admission progress note dated at 3:20 PM, the resident was alert and oriented. Review of the Admission Assessment (AA) dated Jex order 28.4b1, Resident #1 was assessed as not having any behaviors and NJ ex order 26.4b1 NJ ex order 26.4b1, however Resident #1 was observed by Surveyor #1 (S1) and Surveyor #2 (S2) on 07/11/24 at 11:04 AM, NJ ex order 26.4b1 Review of the physician's orders (PO) reflected that there were no orders for the , however a PO order dated reflected an order to NJ ex order 26.4b1 . There was no consent signed for the use of the NJ ex order 26.4b1 Review of the resident's Individualized Care Plans , revealed that a CP was not (CP) dated NJ ex order 26.4b1 . The CP did not address that the resident NJ ex order 26.4b The CP did not address that the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _				29/2024
	ROVIDER OR SUPPLIER	AND REHAB CENTER	,	STREET ADDRESS, CITY, STATE, ZIP OF 65 JAY STREET NEWARK, NJ 07103	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCY	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 603	address and common and	mentation on the CP to from NJ Ex Order 26.4(b)(1) munity dining. AR, Resident #2 was admitted the diagnoses which included Ab1 A comprehensive MDS and unavailable for review. X order 26.4b1 #2 was observed by Surveyor 2 on 07/11/24 at 10:44 AM, Ab1 sician's orders (PO) reflected orders for the use of orders for the use of order the Treatment cord (TAR) reflected an order NJ ex order 26.4b1 dent's CP dated NJ ex order 26.4b1 The CP did not address that the order 26.4b1 The CP did not address that the order 26.4b1 The CP did not address that the order 26.4b1 The CP did not address that the order 26.4b1 The CP did not address that the order 26.4b1 The CP did not address that the order 26.4b1 The CP did not address that the order 26.4b1 The CP did not address that the order 26.4b1 The CP did not address that the order 26.4b1	F	503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 65 JAY STREET NEWARK, NJ 07103	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 603	from attending comm community dining. 3. According to the Al to the facility on NJ ex order 26.4th Review of the AA data Resident # 3 was assembled Review of a Progress revealed Resident # 3 Review of the CP initing CPs were initiated NJ ex order 26.4th According to the Al into the facility which included but no Review of the Order Sphysician order (PO) Further review reveal	R, Resident #3 was admitted with diagnoses which old Wex order 26.4b1 a Note (PN) dated NJ ex order 26.4b1 atted on NJ ex order 26.4b1 AR, Resident #4 was admitted of 26.4b1 By ex order 26.4b1 Commany Report revealed a	F	503			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _				C 29/2024
	ROVIDER OR SUPPLIER	D REHAB CENTER		65 JA	ET ADDRESS, CITY, STATE, ZIP CODE Y STREET ARK, NJ 07103	1 017	23/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 603	Review of the AA date	ed ^{NJ ex order 26.4b1} , the resident	F 6	603			
	was assessed as <mark>NJ</mark> , and	ex order 26.4b1 NJ ex order 26.4b1					
	Review of the resider NJ ex order 26.4k						
	Review of the admiss dated stated NJ ex order resident NJ ex order	ion summary progress note 37 PM, revealed the 26.4b1.					
	5. According to the Al admitted to the facility diagnoses which NJ						
	Review of the PN dat Resident # 5 NJ ex	ed Nuexorder 26.461, revealed that order 26.4b1 .					
	Review of the AA date was assessed as NJ	ed Nuex order 26.4b1, the resident ex order 26.4b1					
	Review of the CP initi NJ ex order 26.4k						
	6. According to the Al admitted to the facility						
	Review of Resident # resident was admitted diagnoses NJ ex or	to the facility with					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		315236	B. WING _			C 07/29/2024		
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 603	Continued From page	e 61	F 6	503				
		ed NJ ex order 26.4b1, the resident J ex order 26.4b1						
	Review of the CP init no CPs NJ ex orde							
	7. According to the A to the facility on NJ ex order 26.4							
	Review of a PN date Resident # 7 NJ ex							
	The AA dated NJ ex order 26.4							
	Review of the CP init CPs were initiated re	iated ^{NJ ex order 26.4b1} , revealed no garding NJ ex order 26.4b1						
		R, Resident #8 was admitted cility with diagnoses which 01						
	Review of the AA dat the resident was asso	ed ^{NJ ex order 26.4b1} revealed that essed as <mark>NJ ex order 26.4b1</mark>						
	Review of a PN date Resident # 8 NJ ex							
	Review of the Care F revealed no CPs wer							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING			C 07/29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING A	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 65 JAY STREET NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 603	Review of a PN date revealed that the resident was as however. Surveyor #1 and Suresident in the room. Review of the physithat there were no constructed by a conditional physical phy	AR, Resident #9 was admitted agnoses which included but 4b1 ed NJ ex order 26.4b1 at 1:36 PM, sident NJ ex order 26.4b1 ated NJ ex order 26.4b1 cian's orders (PO) reflected by ex order 26.4b1 cian's orders (PO) reflected by ex order 26.4b1 cian's orders (PO) reflected by ex order 26.4b1 cients found in the medical expect of NJ ex order 26.4b1 seents found in the medical expect of NJ ex order 26.4b1 ated NJ ex order 26.4b1 seents found in the medical expect of NJ ex order 26.4b1 ated NJ ex order 26.4b1 ated NJ ex order 26.4b1 ated NJ ex order 26.4b1	F 6	03			
	NJ ex order 26.4	d not address that the resident 101 101 101 101 101 101 101 1					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
		315236	B. WING			C 07/29/2024	
NAME OF PI	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY,	STATE, ZIP CODE	07/29/2024	
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		65 JAY STREET NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		
F 603	CP to address 10. According to the Adiagnoses which included for the PO data of	and community dining. AR, Resident #10 had uded but not limited to; older 26.4b1 and community dining. AR, Resident #10 had uded but not limited to; older 26.4b1 and corder 26.4b1 are order 26.4b1 are order 26.4b1 AR, Resident #11 was you've order 26.4b1 AR, Resident #11 was you've order 26.4b1 AR, Resident #11 was you've order 26.4b1 are order 26.4b1	F	503			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		315236	B. WING		C 07/29/2024			
	ROVIDER OR SUPPLIER	ID REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 603	Review of the PO reforders for the use of Treatment Administra an order dated Review of the CP da CP was not impleme The CP did not address that the resident NJ documentation on the from attending community dining. The comprehensive an assessment tool to care, was in progress #11, and unable to both The facility Admission which included all docresponsible person in	at 10:44 AM, New order 28.46 at 10:44 AM, New order 26.46 at 10:44 AM, however ation Record (TAR) reflected at 10 New order 26.46 at	F 60	03				
F 604 SS=K	CFR(s): 483.10(e)(1) §483.10(e) Respect), 483.12(a)(2)	F 60)4		8/20/24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		E SURVEY IPLETED
		315236	B. WING _			C
NAME OF P	ROVIDER OR SUPPLIER	313230	5:	STREET ADDRESS, CITY, STATE, ZIP CO		7/29/2024
TVAINE OF T	NOVIDEN ON OUT FIEN			65 JAY STREET	DE .	
SINAI PO	ST ACUTE NURSING	AND REHAB CENTER		NEWARK, NJ 07103		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 604	Continued From p	page 65	F 6	504		
	and dignity, include	-				
	physical or chemi purposes of discip	e right to be free from any cal restraints imposed for oline or convenience, and not he resident's medical symptoms, 483.12(a)(2).				
	neglect, misappro and exploitation a includes but is no corporal punishm any physical or ch	the right to be free from abuse, opriation of resident property, is defined in this subpart. This it limited to freedom from ent, involuntary seclusion and nemical restraint not required to is medical symptoms.				
	§483.12(a) The fa	cility must-				
	from physical or of purposes of discipare not required to symptoms. When indicated, the facilal ternative for the document ongoin restraints.	sure that the resident is free shemical restraints imposed for pline or convenience and that to treat the resident's medical the use of restraints is lity must use the least restrictive least amount of time and g re-evaluation of the need for		1. All <mark>NJ Ex Order 26.4(b</mark>)(1) have	
	Based on observaresident medical facility documenta facility failed to en NJ ex order 26	records and other pertinent ation it was determined the asure that 11 of 11 residents 6.4b1 (Resident #1, 2, 3, 4, 5, 6, 7, 8,		been discharged from the fa 2. All Justice involved Resident potential to be affected by the practice. 3. All administrative staff will	cility. ents have the is deficient be	
	9, 10 and 11) NJ	ex order 26.4b1		reeducated on the important	ce of ensuring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _				C 29/2024	
NAME OF P	ROVIDER OR SUPPLIER	L	1	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	23/2024	
				65 .	JAY STREET			
SINAI PO	ST ACUTE NURSING AN	D REHAB CENTER			WARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 604	dignified manner had the state of the state	the likelihood to cause reder 26.4(b)(1) and reder 26.4(b)(1) and reder 26.4b1 J ex order 26.4b1 is was cited as a pattern that zes the health and safety of all other residents that reside resulted in an Immediate resulted resul	F		that residents are free from physical restraints. 4. The Administrator/designee will audiresidents a month x 4 months to ensure they are free from physical restraints. Audit findings will be shared with the Q committee monthly x 4 months.	е		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING			C 07/29 /2	2024	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO		0112312	2024	
				65 JAY STREET				
SINAI POST ACUTE NURSING AND REHAB CENTER				NEWARK, NJ 07103				
	CUMMA DV C	CATEMENT OF DEFICIENCIES		·	CODDECTION		0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) OMPLETION DATE	
F 604	Continued From pag	e 67	F 6	504				
		ified the removal plan on-site rmined the was removed as						
	The findings as are fo	ollows:						
	Surveyors on Federa services to Justice In 12/23/2016, S & C 16 Skilled Nursing Facili have autonomy and extent practicable reg	CMS) updated Guideline to all Requirements for Providing avolved individuals, revised 6-21-ALL, documented atties must permit residents to achoice to the maximum garding how they wish to live and receive care with the						
	"Resident Rights" inc would be treated equ sex, ethnicity, religion or mental disability, s sexual orientation, or expression. The resid with dignity and resp any physical or chem the purposes of disci- resident has a right to the community and p activities both inside right to receive visitor subject to the resider when applicablerig groupsthe right for accommodations, me	dent has a right to be treated ect including being free from hical restraints imposed for pline or convenience. The prince interact with members of participate in community and outside the facility the price of his or her own choosing into participate in family and personal privacy includes edical treatment, telephone sonal care, visits and						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A. BOILDI	NO _		Ι,	С
		315236	B. WING				29/2024
NAME OF P	ROVIDER OR SUPPLIER	•	•		TREET ADDRESS, CITY, STATE, ZIP CODE 5 JAY STREET		
SINAI POS	ST ACUTE NURSING	AND REHAB CENTER		N	IEWARK, NJ 07103		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	Continued From pa	age 68	F	604			
	and titled, "Physical "restraints should of well-being of the real ternatives have be Restraints shall on resident's medical discipline of staff or restraints is indicated alternative will be used to placing a resided pre-restraining associates determine the need sassessment shall be underlying causes symptom and to derestrictive intervents symptoms. Restraithe written order of obtaining consent representative. The specific reason for will be used to be symptom; and the time for the use of 1. According to the Resident # 1 was a diagnoses NJ ex revealed Resident NJ ex order 26.be progress note date	Admission Record (AR), admitted to the facility with order 26.b41 Review of the ment (AA) dated Next Order 26.b41, and assessed as Next Order 26.b41 According to the admission					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
						С	
		315236	B. WING _		(7/29/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
011141 000	T 4011TE NUIDOINO 4NI	DELLAR OFNIER		65 JAY STREET			
SINAI POS	ST ACUTE NURSING AND	O REHAB CENTER		NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 604	Continued From page	• 69	F 6	604			
F 604	Individualized Care P were implemented for restraints. Further rev revealed that Resider Admission Agreement Minimum Data Set (M not yet completed. 2. According to the AF to the facility with diag of the AA dated was assessed as NJ NJ ex order 26.b4 of the Individualized C CPs were implemented Further rev revealed that Resider or NJ ex order The comprehensive N was in progress and r 3. According to the AF to the facility with diag Resident #3 was asse NJ ex ord A review of Plans (CP) revealed r for the use of NJ ex or of the medical record NJ ex order 26.b4	tans (CP) revealed no CPs the use of physical iew of the medical record at #1 did not sign the facility t (AA) NJ ex order 26.b41 The comprehensive IDS) was in progress and R, Resident #2 was admitted gnoses NJ ex order 26.b41 Review Review The corder 26.b41 The corder 26.b41 The comprehensive The comprehe	F	504			
	4. According to the AF	R, Resident #4 was admitted					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _				C 29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 65 JAY STREET NEWARK, NJ 07103)E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE	
F 604	NJ ex order 26.b41 NJ ex order 26.b According to the administed the Resident #4 NJ ex order 26.b According to the administed for the Further review of the Resident #4 NJ ex order 26.b Individualized Care Fivere implemented for the facility with dialance or revealed that Reside AA or consent for the The comprehensive I was in progress and 6. According to the A to the facility with dialance or revealed Resident #6 Individualized Care Fivere implemented for the The comprehensive I was in progress and 6. According to the A to the facility with dialance or Revealed Resident #6 Individualized Care Fivere implemented for the Care Fiver	gnoses which was assessed as was assessed as or NJ ex order 26.b41 or he AA indicated the resident at 1:37 PM, the resident areview of the Individualized caled no CPs were use of NJ Ex Order 26.4(b)(1) medical record revealed that or The num Data Set (MDS) was in completed. R, Resident #5 was admitted gnoses which included sessed as not having any gno	F6	604				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/29/2024
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 65 JAY STREET NEWARK, NJ 07103	CODE	31/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 604	Service progress or resident #6 was as with a Basic Interview out of 15 which NJ ex order 26.b4. Care Plans (CP) resimplemented for the Further review of the Resident #6 NJ excomprehensive Min progress and not by 7. According to the #7 was admitted to which included dated which included for the requiring at 11:12 phin of the Individualize CPs were implementative CPs were implementative consent for the comprehensive NJ ex order 26.4 (b) (1) Review or revealed Resident having any NJ Ex Order 26.4 (b) (1)	According to the Social at 9:45 PM, assessed as JEVOM and JEVOMONIA at 9:45 PM, assessed as JEVOMONIA at 9:45 PM, assessed as JEVOMONIA at 9:45 PM, assessed at 9:45 PM, as	F	504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _				29/2024
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD)E	<u> </u>	
SINAI PO	ST ACUTE NURSING AN	D REHAB CENTER		65 JAY STREET NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 604	were implemented for review of the medica Resident #8 NJ ex of for the use of NJ ex of comprehensive Minimprogress and not yet 9. According to the Ato the facility with dia Review of revealed Resident #9 admission note dated resident was NJ Ex review of the Individure vealed no CPs wer NJ Ex Order 26.4(b)(1) Frecord revealed that facility AA or consent The composet (MDS) was in procompleted. 10. According to the admitted to the facility NJ ex order 26.bod dated 07/02/24, reveassessed as not having requiring NJ Ex Order 26.bod addission summary NJ Expression Set (MDS) at 2:40 PM, A review of the Individual revealed no CPs were set (MDS) was in procompleted.	A review of the lans (CP) revealed no CPs of the use of the lans (CP) revealed no CPs of the use of the use of the use of the land of the	F	504			

I ?		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/ 29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 65 JAY STREET NEWARK, NJ 07103		77720724	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 604	The composition (MDS) was in progres 11. According to the #11 was admitted to which included NJ ex dated NJ ex da	rehensive Minimum Data Set ess and not yet completed. Admission Record Resident the facility with diagnoses order 26.b41. Review of the AA caled Resident #11 was ring any [MEX Order 26.4(b)(1)]. gress note dated [MEX ORDER 26.541] at	F6	04			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		315236	B. WING _			C 07/29/2024	
	ROVIDER OR SUPPLIER	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 604	interviewed the Mini (MDSC) who stated entry MDSs completed MDSs were not compared admission. The MDS with the entry MDSs. On 07/11/24 at 10:20 Surveyor #2 toured interviewed Licensed who stated that he wit was stated that there were wit was stated that there were without the management of the mooth of the stated allowed to enter the allow the surveyors (Resider SUSM explained to that the services. He stated attend facility activities.)	mum Data Set Coordinator that the eleven New order 26.45 had ted, however comprehensive upleted until day 14 of SC provided the surveyors for all New order 26.45 O AM, Surveyor #1 and the floor and d Practical Nurse (LPN#1) vorked for an agency and that vorking at the facility. LPN #1 re New order 26.45 S AM, Surveyor #1 observed allway. The six residents that floor were observed in their by N Ex Order 26.4(b)(1) O AM, Surveyor #1 and wed a gentleman outside in ntified himself as a contracted That the surveyors were not New order 26.45 The Surveyor #1 and Surveyor #2 The facility for rehabilitation that all N ex order 26.4b1 ained that wearing of on the resident's medical	F	504			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 07/ 29/2024	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP OF 65 JAY STREET NEWARK, NJ 07103		1112312024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 604	On 07/11/24 at 10: Resident #5 and # On 07/11/24 at 10: from the hallway R NJ ex order 26. At 07/11/24 at 11:0 Surveyor #2 toured surveyors interved there were and #10). On 07/11/24 at 11: Surveyor #2 were expressed in bed with and w	. He stated that and could not could	F	504			
		d was good and that they were					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			07/2) 29/2024	
	ROVIDER OR SUPPLIER ST ACUTE NURSING A	ND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 65 JAY STREET NEWARK, NJ 07103	ODE	, .	107202-7	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 604	NJ Ex Order 26. able to NJ Ex Order Was NJ ex order On 07/11/24 at 11:1 Surveyor #2 were gus FoIA (b)(6) to i was NJ ex order 26.4 they were admitted diagnoses of NJ ex Order 26.4 they were admitted diagnoses of NJ ex Order 26.4 they were admitted diagnoses of NJ ex Order 26.4 that they received in to pick their own me honored food prefet that they had NJ ex Order 26.4 showering. The resionly time that they of NJ ex Order 26.4 identified the resident #3 NJ ex Order 26.4 identified the resident #3	that they were not allowed to 4(b)(1) and were only er 26.4(b)(1) with their 44 stated that otherwise there 26.4b1 2 AM, Surveyor #1 and iven permission from the interview Resident # 1 who 11. The resident stated that to the facility with the 12 corder 26.4b1 and 13 corder 26.4b1 13 Resident #4 stated ineals 14 stated ineals 15 corder 26.4(b)(1) except for ident stated that that was the could 15 corder 26.4(b)(1) except for ident stated that that was the could 17 Ex Order 26.4(b)(1) 20 AM, Surveyor #1 and ewed the Licensed Practical or (LPN/UM #1) who stated sided on the 16 corder 26.4b1 4b1 She also	F	504				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	((X3) DATE SURVEY COMPLETED
		315236	B. WING _			C 07/29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 65 JAY STREET NEWARK, NJ 07103	E	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		N SHOULD BE	
F 604	surveyor #2 interview with informed by the Licer admitted to the facility told not to complete a admission. She state residents with a bask admission, however NJ Ex Order 26.4 On 07/11/24 at 11:42 Surveyor #2 interview who state employed by the facing She explained what he were admitted to the the admission processervice assessment explained the processervice assessment explained the processervice assessment explained the facility list of resident rights, information and pain that based on federal homes keeping a residents were being and not being able to form a NJ Ex Order 26.4 residents were being and that that was again that the facility could medical needs, howere	AM, Surveyor #1 and wed the US FOIA (B) (6) that when the y that she was an activities assessment on the residents were not to the residents when residents facility and stated that during ses, she performed a social with the resident. She so f completing an advanced planning and held Care Plant that when the so for completing an advanced planning and held Care Plant that when the y she provided them with a advanced directives, billing management. She stated I regulations in nursing fident of the provided that the stated I regulations in nursing fident of the provided that the stated I regulations in nursing fident of the provided that the stated I regulations in nursing fident of the provided that the provide	F6	504		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 604 Continued From page 78 F 604 (CMS) memo S & C: 16-21-ALL, with revised ex order 28.4b1, he understood that it was against federal NJ ex order 26.4b1 or . He stated that he called the nursing home in New York to inform them to stop sending to the facility, but they just kept sending them. He stated that he did not refuse to admit the residents to the facility because the nowhere else to go. He then stated that it was not the facility that was NJ ex order 26.4b1 on , it's the NJ ex order 26.4b1 that was imposing them. He added that the facility was aware that the were NJ ex order 26.4b1 by the facility than other residents and that it was not the facility's standard of practice however he felt that the NJ ex order 26.4b1 NJ Ex Order 26.4(b)(1) and that he was between the NJ ex order 26.4b1 On 07/12/24 at 9:40 AM, Surveyors #3 and #5 attempted resident interviews with Resident #8 and #9 but were told by the NJ ex order interviews were not permitted but could be observed through the doorway of their rooms. The surveyors observed Resident #8 in their room in a NJ ex order 26.4b1 connected by a NJ ex order 26.4b1 to the resident's bed. Resident #9 was observed in bed with an to the resident's bed. On 07/12/24 at 9:45 AM, Surveyor #5 interviewed the Licensed Practical Nurse (LPN #1) who was the nurse for Residents #8 and #9. LPN #1 stated that the NJ ex order 26.4b1 On 07/12/24 at 12:15 PM, Surveyor #1 and Surveyor #2 interviewed the who stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315236	B. WING _			07/2	; 29/2024	
	ROVIDER OR SUPPLIER	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD B		(X5) COMPLETION DATE	
F 604	to NJ Ex Order 26.4(b)(1) or were all a form of the personal that was e residents, it was the On 07/12/24 at 1:24 phone interview with when the NJ ex order 26.4 or that the NJ ex order 26.4 or 07/15/24 at 08:45 together toured the NJ ex order that the NJ ex order 26.4	JEX Order 26.4(b)(1), residents and not being able NJ EX Order 26.4(b)(1) however it was not inforcing this on the NJ ex order 26.4b1 PM, Surveyors conducted a the US FOIA (B) (6) he had been on vacation re admitted to the facility. He in NJ ex order 26.4b1 ey were all NJ ex order 26.4b1 MD further stated that he did in intheir rooms	F	604				
	toured the Name of the Resident #11 in hallw NJ ex order 26.4 the surveyors observed in their rooms with Name of the Name of t	And the state of t						

INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (X3) DATE (COMP		ETED			
315236	B. WING		O7/2		
HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103	1 0112	07/29/2024	
ST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETION DATE	
	F 60	04			
must provide, based on sament and care plan ach resident, an ongoing ents in their choice of onsored group and idependent activities, crests of and support the chosocial well-being of ing both independence inmunity. In the enterprise of the provided in the enterprise of ing both independence in the enterprise of indep	F 67	 All NJ Ex Order 26.4(b)(1) been discharged from the facility All Justice involved Residents potential to be affected by this dipractice. All administrative staff will be reeducated on the importance or residents with a meaningful groundividualized activity program their preferences. The Administrator/designee with residents a month x 4 months to 	have y. s have the eficient f providing up and nat reflects vill audit 5 o ensure	3/20/24	
	er 26.4b1 not possible at this time. eeds Each Resident must provide, based on sament and care plan ach resident, an ongoing ents in their choice of posored group and independent activities, erests of and support the vichosocial well-being of ing both independence inmunity. not met as evidenced terview, review of er pertinent facility termined that the facility ingful group and grams that reflected the	### BENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) ### BENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) ### BENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) ### F 60 ### BENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) ### F 60 ### BENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFY INFORMATION) ### F 60 ### BENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFY INFORMATION) ### F 60 ### BENT OF DEFICIENCIES ST BE PRECEDED BY FULL TAG ### PREFIX TAG ### F 60 ### BENT OF DEFICIENCIES ### BENT OF DEFICE ### BENT OF DEFICIENCIES ### BENT OF DEFICIE	### STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STAY STREET NEWARK, NJ 07103 PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE APDEFICIENCY) PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103 BENT OF DEFICIENCIES STREET DEFICIENCIES STREET DEFICIENCIES STREET NEWARK, NJ 07103 PROVIDER'S PLAN OF CORRECTION FOR CROSS-REFERENCED TO THE APPROPRIATE DESTIGNATION F 604 F 604 F 609 Thust provide, based on sament and care plan ach resident, an ongoing ents in their choice of onsored group and independent activities, erests of and support the richosocial well-being of ng both independence numunity. The pertinent facility termined that the facility agril group and grams that reflected the sistentified for 11 of 11 (Resident #1, and 11), reviewed for noted by the following: for Medicare and pupdated Guideline to THE ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103 PROVIDER'S PLAN OF CORRECTION FROM PROPRIATE PROVIDER'S PLAN OF CORRECTION FROM PROVID	

		IDENTIFICATION NUMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _				0	
NAME OF D	201/1050 00 01 1001 150	313236	B. WING _	OTDE	TET ADDRESS SITV STATE ZID SODE	07/	29/2024	
NAME OF PI	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE			
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER			AY STREET			
				NEW	/ARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 679	Continued From page	e 81	F 6	679				
	12/23/2016, S & C 16 Skilled Nursing Facilit have autonomy and c extent practicable reg	volved individuals, revised i-21-ALL, documented ties must permit residents to choice to the maximum larding how they wish to live and receive care with the g home residents.		p	activity program that reflects their preferences. Audit findings will be shar with the QAPI committee monthly x 4 months.	ed		
	1 was admitted to the diagnoses which include admission progress in PM, the resident was of the Individualized CP were implemented.	According to the ote dated NJ ex order 26.4b1 at 3:20 NJ ex order 26.4b1. A review Care Plans (CP) revealed no d for activities, or NJ ex order 26.4b1 at 3:20 NJ ex order 26.4b1. A review Care Plans (CP) revealed no d for activities, or NJ ex order 26.40011						
	#2 was admitted to the diagnoses which NJ revealed no CPs were with attending activities	ex order 26.4b1 A review of the CP e NJ ex order 26.4b1 es, and NJ Ex Order 26.4(b)(1) The comprehensive MDS						
	#3 was admitted to the diagnoses which NJ erevealed no CPs were with with activitie except for showers. The was in progress and the According to the According	A review of the CP implemented for NJ Ex Order 26.4(b)(1) The comprehensive MDS						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			l	29/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	077	25/2024
CINAL DO	ST ACUTE NUIDSING AN	D DELIAD CENTED		65 JAY STREET			
SINAI PU	ST ACUTE NURSING AN	D REHAD CENTER		NEWARK, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 679	According to the administration assessment and the administration an	ex order 26.4b1 . The nt indicated the resident indicated the CP revealed no 26.4b1 . Indicated indic	F	679			

AND DLAN OF CODDECTION IDENTIFICATION NUMBER		(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315236	B. WING		١ .	C 0 7/29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING ANI	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103		3112312024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 679	diagnoses which included and the CP revealed no with with was of the Admission progress of the Admission progress of the CPs was in progress of the Admission progress and	ission summary note dated to staff. A review to staff. A review of CPs were implemented activities, and state of activities, and state of activities, and state of and not yet completed. In the resident was to staff. A review of cPs were implemented activities, and state of activities of activities, and state of activit	F	679		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 679 Continued From page 84 F 679 A review of the CP revealed no CPs were implemented for NJ ex order 26.4b1 and NJ ex order 26.4b1 . The comprehensive MDS 11. According to the Admission Record Resident #11 was admitted to the facility on diagnoses which NJ ex order 26.4b1 According to the progress note dated 4:08 PM, the resident NJ ex order 26.4b2 A review of the CP revealed no CPs were implemented for with activities, and NJ ex order 26.4b1 . The comprehensive MDS was in progress and not yet completed. On 07/11/24 at 10:30 AM, interviews were attempted by Surveyor #1 and #2, and was prohibited by the NJ Ex Order 26.4(b)(1) interviewed on . and stated required approval by the that all to have interviews or visitation. On 07/11/24 at 11:05 AM, Surveyor #2 was to interview Resident allowed by the #4 who stated they NJ ex order 26.4b1 and not allowed to NJ Ex Order 26.4(b)(1) other residents. On 07/11/24 at 11:12 AM, Surveyors #1 and #2 interviewed Resident #1, who stated that they were only NJ ex order 26.4b1 On 07/11/24 at 11:35 AM, Surveyor #1 and Surveyor #2 interviewed the US FOIA (B) (6 who stated that she was informed by the US FOIA (B) (6)

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315236 R WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 679 Continued From page 85 F 679 US FOIA (B) (6) that when the admitted to the facility that she was to with them. She stated that she was told not to complete an activities assessment on admission. She stated that she provided the residents with a basket of puzzles and cards on admission, however the residents were not to attend any activities out of their rooms. On 07/12/24 at 9:30 AM, Surveyors #3, #4, and #5 interviewed the 3rd floor US FOIA (B) (6) who stated the remain in their rooms at all times and did participate in group activities. On 07/12/24 at 9:40 AM, Surveyors #3 and #5 attempted resident interviews with Resident #8 and #9 but was told by the NJEx Order 28.4(b)(interviews were not permitted but could observed through the doorway of their rooms. On 07/12/24 at 9:45 AM, Surveyor #5 interviewed the Licensed Practical Nurse (LPN #1) who is the nurse for both Resident #8 and #9. LPN#1 stated NJ Ex Order 26.4(b)(1) except on shower days. LPN #1 stated the participate in group activities. A review of the electronic medical record (EMR) for Resident #8 and #9 revealed that Resident #8 had a Physician Order (PO) with a start date of for, NJ ex order 26.4b1." Resident #9 had a PO with a start date of NJ Ex Order 26.4(b)(1) SCreen, as tolerated." No notes or care plans were noted for either resident. On 07/15/24 at 10:00 AM, the provided the surveyors with a facility policy titled, Activity Programs. The activity programs policy with a revised date of NJ ex order 26.4b1 states under the

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OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		315236	B. WING		C 07/29/2024
	ROVIDER OR SUPPLIER	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103	0112312024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE COMPLETION
F 835	"1. Our activity prograencourage maximum are geared to the ind Our activity programs small and large group to meet the needs an and include, as a mir scheduled to increasinterest and friendshienjoyment. NJAC 8:39-7.3(a) Administration	and implementation section,	F 6		8/20/24
SS=L	enables it to use its refficiently to attain or practicable physical, well-being of each re This REQUIREMENT by: Complaint # NJ 1754 Refer to F 550 K, Ref 561 K, Refer to F 603 F to 679 E. Based on interviews, facility documents, it facility failed to a.) e implemented policies	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced 115 fer to F 557 K, Refer to F B K, Refer to F 604 K, Refer record review, and review of was determined that the ensure the facility and procedures for Self Determination as well dures to prevent		1. All NJ ex order 26.4b1 has been discharged from the facility. 2. All Justice involved Residents have potential to be affected by this deficipractice. 3. The U.S. FOIA (b) (6) will be reeducated ensuring that policies and procedure being followed for resident rights and self-determination, prevent physical restraints and seclusion, admission agreements are being signed upon admission, residents are afforded	ent ted on es are

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315236	B. WING _			1	29/2024
	ROVIDER OR SUPPLIER ST ACUTE NURSING AN	D REHAB CENTER		STREET ADDRESS, CITY, STATE 65 JAY STREET NEWARK, NJ 07103	, ZIP CODE	1 011.	20/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BI ED TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 835	ensure 11 of 11 NJ et (Resident #1, 2, 3, 4, NJ ex order 26.44 and c.) we serving meals in a dig communicate with vis will . The failure to en and maintained syste efficient to operate the safely meet residents cause NJ Ex Order 26.4(b)(1) a which resulted in an I The Immediate Jeopathe date that the first admitted to the facility . The IJ situation 10, and 11 were obseined the situation on 11 were obseined the date that the first admitted to the facility . The IJ situation 10, and 11 were obseined the situation on 07/12/24 community dining, be dignified manner, interesidents, communicate NJ Ex Order 26.4(b)(1) The facilities US FO situation on 07/12/24 Immediate Jeopardy An acceptable remove 7/29/24 at 9:59 AM, in facility will take to preoccurring or recurring corrective action plant	ex order 26.4b1 5, 6, 7, 8, 9, 10, and 11) b.) o1 re afforded the Nex order 26.4(b)(1) re afforded the Nex order 26.4(b)(1	F	autonomy to participal community dining, set dignified manner, free visitors, and to leave to the visitors and proceed followed for resident results and seclusive agreements are being admission, residents a autonomy to participal community dining, set dignified manner, free visitors, and to leave to Operations will complevaluation at the endevaluate the performal Administrator and will additional education is results of these audits the QAPI committee results.	rving meals in a ally communicate war oom at will. Innee will audit 5 months to ensure edures are being ights and event physical on, admission are afforded te in group activitation meals in a ely communicate war oom at will. VP of ete a performance of 90 days to ance of the determine if is required. The sawill be reported to the communicate was a service of the determine if its required. The sawill be reported to the communicate was a service of the determine if the sawill be reported to the communicate will be reported to the	with e with of e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		315236	B. WING			C)7/29/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 65 JAY STREET NEWARK, NJ 07103		0112312024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 835	. Administ policies pertaining to ADL's and activities. The survey team ve on 7/29/24, and dete of 7/26/24. The findings were as The facility policy da "Resident Rights" in would be treated eq sex, ethnicity, religio or mental disability, sexual orientation, of expression. The res with dignity and respany physical or cher the purposes of discresident has a right the community and activities both inside right to receive visite subject to the reside when applicableri groupsthe right for accommodations, medium communications, per meetings of family and A review of a facility dated 02/2024, inclexplanation and Comprior to or upon administrations of the residence of the res	m the facility as of singer admit super ad	F8	35			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			07/	29/2024	
	ROVIDER OR SUPPLIER	D REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 65 JAY STREET NEWARK, NJ 07103		• • • • • • • • • • • • • • • • • • • •		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE	
F 835	Continued From pag will inform the reside responsibilities. 2. Exhas the right to exercise resident of the facility of the United States. resident has a right to dignity including the physical or chemical Self-determination. Tand the facility must residents' self-determination. Tand the facility must residents' self-determination resident's choice, incright to choose activitian aspect of his or her limembers of the comoutside the facility, and visitors. 7. Information resident has the right rights and of all the rigoverning resident conduring his or her stay confidentially. The reprivacy and confidentially. The reprivacy and confidential accommodations, metalephone communications.	e 89 Int of the resident's rights and dercise of rights. The resident disse his or her rights as a solution or resident 5. Respect and Dignity. The polybe treated with respect and right to be free of any restraint 6. The resident has the right to, promote and facilitate inination through support of deluding but not limited to the ties, make choices about fe, right to interact with munity both inside and and the right to receive n and communication. The to be informed of his or her						
	and titled, "Physical I "restraints should on well-being of the resi alternatives have been Restraints shall only resident's medical sy discipline of staff con restraints is indicated alternative will be use	mptoms and never for venience. When the use of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 7/ 29/2024	
	ROVIDER OR SUPPLIER	AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 65 JAY STREET NEWARK, NJ 07103	•	11/23/2024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 835	to placing a reside pre-restraining as determine the need assessment shall underlying causes symptom and to crestrictive interver symptoms. Restrathe written order cobtaining consent representative. The specific reason for will be used to be symptom; and the time for the use of the courage maximare geared to the Our activity programs. The acrevised date of Ferolicy interpretation. Our activity programs are geared to the Our activity programs and large guard to meet the needs and include, as a scheduled to increasing provided and activity programs. The second activity programs are geared to the Our activity programs and large guard to the Our activity programs. The second and include, as a scheduled to increasing provided and activity programs policy with a revisuance the policy second activity programs and activity programs.	aints will be documented. Prior ent in restraints, there shall be a sessment and review to ed for restraints. The be used to determine possible of the problematic medical letermine if there are less nations that may improve the aints should only be used upon of a physician and after from the resident and/or ne order shall include the restraint; how the restraint nefit the resident's medical e type of restraint, and period of	F	335			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			C 7/29/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 65 JAY STREET NEWARK, NJ 07103		0112312024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 835	revised date of Febru policy interpretation a "1. Our activity prograencourage maximum are geared to the indi Our activity programs small and large group to meet the needs an and include, as a min are scheduled to incretimulate interest and and enjoyment. A review of the facility with a review date of "Policy" that, "It is the residents admitted to adequate person-cen provide for all their new A review of the undate and Performance State document revealed the Administrator include a.) Develop, maintain policies and procedure in compliance with fer requirements. b.) Determine the perfacility and hire or arm	ivity programs policy with a lary 2024 states under the and implementation section, ams are designed to individual participation and ividual resident's needs. 3. It consist of individual and of activities that are designed do interests of each resident imum: J) Social activities ease self-esteem, to a friendships, and provide fun a timely manner." The facility will have the facility's "Job Description and facility's "Job Description and facility's "Job Description and the duties of the dout not limited to: The facility will have the facility of the dout not limited to: The facility is "Job Description and the duties of the dout not limited to: The facility is "Job Description and the duties of the dout not limited to: The facility is "Job Description and the duties of the dout not limited to: The facility is "Job Description and the duties of the dout not limited to: The facility is "Job Description and the duties of the dout not limited to: The facility is "Job Description and the duties of the dutie	FE	335			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/27/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 835 Continued From page 92 F 835 On 07/11/24 at 09:00 AM, Surveyor #1 and Surveyor #2 interviewed the US FOIA (B) who stated that she was notified by the facilities Cooperate Offices (CO) that entering the facility. She stated that the facilities CO instructed the facilities administration with other residents and that the they needed to be NJ Ex Order 26.4(b)(1). She stated that the would be would be NJ ex order 26.4b1 NJ ex order 26.4b1 She stated that the CO also instructed the facility not to NJ Ex Order 26.4(b)(1) the with other residents in the facility. On 07/11/2024 at 09:35 AM, Surveyor #1 and #2 interviewed the Minimum Data Set Coordinator (MDS) who stated that the eleven entry MDS's completed, however comprehensive MDS's were not completed until day 14 of admission. The MDS provided the surveyors with the entry MDS's for On 07/11/2024 at 10:20 AM, Surveyor #1 and Surveyor #2 toured the NJ ex order 26.4b1 and interviewed the Licensed Practical Nurse (LPN #1) who stated that he worked for an agency and that it was NJ Ex Order 26.451 working at the facility. LPN #1 stated that there were 6 (six) residing on his unit (Resident #2, 5, 6, 8, 9, and 11). He stated that there were NJ Ex Order 26.4(b)(1) the residents and that the residents wore NJ ex order 26.4b1. He continued to explain that he was not sure what the residents' were and was not aware of any that the had. He also added that

he was not aware of any complaints about these

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 835 Continued From page 93 F 835 residents from other residents that resided on his unit. On 07/11/2024 at 10:25 AM, Surveyor #1 observed the from the hallway. The six residents that resided on the observed in their rooms NJ ex order 26.4b1 On 07/11/2024 at 10:30 AM, Surveyor #1 and Surveyor #2 interviewed a gentleman outside in the hallway who identified himself as a contracted U.S. FOIA (b) (6) He stated that the surveyors were not allowed to enter the rooms and would not allow the surveyors to interview the on the 4 (four) West unit (Resident #2, 5, 6, 8, 9, and 11). The us FOIA (b) explained to Surveyor #1 and Surveyor #2 that the were at the facility for rehabilitation services. He stated that all were to wear NJ Ex Order 26.4(b)(1), and all were to be NJ Ex Order 26.4(b)(1). He explained that wearing of NJ Ex Order 26.4(b)(1) depended on the resident's medical condition. He stated that all residents NJ Ex Order 26.4(b)(1)ities and NJ Ex Order 26.4(b)(1) with other residents and could NJ Ex Order 26.4(b)(1) other residents. He stated that the residents could only with NJ Ex Order 26.4(b)(1) for showering or any other reason which was approved by the NJ Ex Order 26.4(b)(1). He stated that must NJ Ex Order 26.4(b)(1) and could not Ex Order 26.4(b)(1) with the other residents. He stated that of anyone must be approved by the or On 07/11/2024 at 10:42 AM, Surveyor #1 observed Resident #5 and #6 from the hallway lying in bed NJ Ex Order 26.4(b)(1)

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 315236 B. WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 835 Continued From page 94 F 835 The residents were observed On 07/11/2024 at 11:20 AM, Surveyor #1 and Surveyor #2 interviewed Licensed Practical Nurse Unit Manager (LPN/UM #1) who stated that Resident #3 resided on the and had the diagnoses of NJ ex order 26.4b1 She also identified the She stated that Resident resident as a #3NJ ex order 26.4b1 She stated that the resident had NJ Ex Order 26.4(b)(1 activities in the room but was in the main activity room because there was no intermingling with long term care residents. LPN/UM #1 stated that Resident #7 also resided on the Nex order 25.4 and had a NJ ex order 26.4b1. She stated that Resident Were the same as Resident #2. On 07/11/2024 at 11:35 AM, Surveyor #1 and Surveyor #2 interviewed the US FOIA (B) (6) who stated that she was informed by the US that when the admitted to the facility that she was to them. She stated that she was told not to complete an activities assessment on admission. She stated that she provided the residents with a basket of puzzles and cards on admission, however the residents were not to attend any activities out of their rooms and mail would go through administration. On 07/11/24 at 11:42 AM, Surveyor #1 and Surveyor #2 interviewed the US FOIA (B) (6

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315236 R WING 07/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **65 JAY STREET** SINAI POST ACUTE NURSING AND REHAB CENTER NEWARK, NJ 07103 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 835 Continued From page 95 F 835 S FOIA (B) (6) who stated that she had been employed by the facility for about NUEX OTHER 25.4 explained what her role was when residents were admitted to the facility and stated that during the admission process, she performed a social service assessment with the resident. Explained the process of completing an advanced directive, discharge planning and held Care Plan meetings. were admitted to She stated that when the the facility she provided them with a list of resident rights, advanced directives, billing information and pain management. She stated that based on federal regulations in nursing homes keeping a resident in the room and not NJ Ex Order 26.4(b)(1) form a NJ Ex Order 26.4(b)(1). She stated that the were being NJ EX Order 26.4 for NJ EX Order 26.4(b)(1) and that was against the federal regulations. On 07/11/24 at 12:20 PM, during an interview with Surveyor # 1 the stated that NJ ex order 26.4b . Further, he confirmed that NJ Ex Order 26.4(b)(1), being served food with plastic and paper products and requiring during activities of daily living were all of federal regulations of Long-Term Care regulations. He concluded that if a long-term care resident was not able to NJ Ex Order 26.4(b)(1 other residents, then that would be a form of On 07/12/2024 at 9:30 AM, during an interview with Surveyor #3 and #5, Unit Manager #3 confirmed that the NJ ex order 26.4b1 Further, she confirmed that the received disposable trays for their meals. Lastly, she confirmed that they NJ Ex Order 26.4(b)(1 for showers on NJ ex order 26.4b1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315236	B. WING _			1	29/2024	
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CC	DE	1 011	23/2024	
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER		NEWARK, NJ 07103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 835	On 07/12/24 at 09:34 Surveyor #2 interview that the facility could medical needs hower Centers for Medicare (CMS) memo S & C: 12/23/2016, he unde federal regulation to He stated that he cally York to inform them to the facility, but they justated that he did not residents to the facility nowhere else to go. If the facility that was in the successful it's the imposing them. He are aware that the successful that the stated that the successful that the stated that the stated that the successful that the stated that the stat	AM, Surveyor #1 and wed the strong who stated accommodate the were after he received the and Medicaid Services 16-21-ALL with revised date restood that it was against the strong or store and medicaid services the strong the nursing home in New to stop sending the strong them. He refuse to admit the refuse to admit the ty because the strong that it's not imposing these strong that it's not imposing these strong that is dided that the facility was were being strong thousand that it was dard of practice however he	F	335				
	On 07/12/24 at 12:15 Surveyor #2 interview that resident being NIEX Order 26.4(b)(1) other to NIEX Order 26.4(b)(1) or were all a form of the USFOIA (B) that was eresidents, it was the On 07/12/24 at 1:24 phone interview with who stated that he had the NIEX OFFOIA (B) were administration of the NIEX OFFOIA (B) were administr	PM, Surveyor #1 and wed the stated JEX Order 26.4(b)(1), residents and not being able the main dining rooms however it was not afforcing this on the surveyor.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315236	B. WING			C 07/29/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 65 JAY STREET NEWARK, NJ 07103	CODE	07/29/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 835	On 07/15/24 at 09:4 5 together interviewe until he met with or w Jersey Department of for Medicare and Me contracted company not submit a removal Immediate Jeopardie have to be removed not possible at this til On 07/15/2024 at 9:2 with the Surveyor # 2 with the Surveyor # 2 No 000/2040 and still be a Record (EMR) under reveal any orders for reveal a dietary orde spoons are to be on	A AM, Surveyor #2, # 3 and # and the stated that who stated that was contacted by the New of Health (NJDOH), Centers dicaid (CMS), and a [name redacted] he could a plan for any of the se because the would from the facility and that was me. 15 AM, during an interview 2 and # 3, the confirmed that the dents were still being ing state of the specifying that only plastic the tray. 2 EMR under Care Plan did for activities, choices, or	F	335			

New Jersey Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 50.2510.		С
		060713	B. WING		07/29/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
SINAI POS	ST ACUTE NURSING AND	O REHAB CENTER 65 JAY ST	REET NJ 07103		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
S 000	Initial Comments		S 000		
0.500	8:39, standards for lice Facilities. The facility Correction, including a deficiency and ensure implemented. Failure result in enforcement the provisions of the N Code, Title 8, chapter licensure regulations.	Jersey Administrative code, sensure of Long Term Care must submit a Plan of a completion date for each e that the plan is to correct deficiencies may action in accordance with New Jersey Administrative 43E, enforcement of			
S 560	8:39-5.1(a) Mandator (a) The facility shall confederal, State, and longer regulations.	omply with applicable	S 560		8/20/24
	by: Based on observation pertinent facility document determined the facility required minimum directions as mandated by	is not met as evidenced n, interview, and review of mentation, it was failed to maintain the ect care staff-to-resident to the state of New Jersey. It was evidenced by the		1. There was no negative outcome to residents on the shifts identified as no meeting the NJ staffing requirements during the 7:00am -3:00pm shift on th dates 6/23/24, 6/24/24, 6/25/24, 6/26/6/27/24, 6/28/24, 6/29/24, 6/30/24, 7/7/2/24, 7/3/24, 7/4/24, 7/5/24, and 7/6	e 24, 1/24,
	112. An Act concernin nursing homes and su Revised Statutes. Be and General Assembl Jersey: C.30:13-18 M	linimum staffing ing homes effective 2/1/21.		 All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios. The following measures have been into place to prevent the deficient practice from recurring: Advertisement / Job postings for CNA's have been posted 	put tice

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

TITLE

Electronically Signed

(X6) DATE 08/07/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		060713		B. WING		C 07/29/2024
	ROVIDER OR SUPPLIER	D REHAB CENTER	STREET ADDR 65 JAY STRI NEWARK, N		TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
S 560	requirements as may every nursing home a P.L.1976, c.120 (C.3 to P.L.1971, c.136 (Comaintain the following-to-resident ratios: (1) one certified nurse residents for the day (2) one direct care staresidents for the ever fewer than half of all certified nurse aides, shall be signed in to aide and shall performand (3) one direct care staresidents for the night direct care staff memore certified nurse aide a aide duties b. Upon any expansion ursing home, the nursing home, the nursing home, the nursing home consofthe expansion of the expansion at of this staffing ratios shall be place. (2) If the application subsection a of this staffing ratios and this staffing ratios are sides, required direct care staffined nurse aides, required nurse aides, required nurse aides, required nurse aides, required nurse aides, requir	be established by law as defined in section 2 0:13-2) or licensed pure 2:26:2H-1 et seq.) shall g minimum direct care et aide to every eight shift; aff member to every 10 ning shift, provided that staff members shall be and each staff member work as a certified nurse metrified nurse aide of aff member to every 14 t shift, provided that each staff, provided that each staff member to every 14 t shift, provided that each staff member to every 14 t shift, provided that each ber shall sign in to worn and perform certified nurse on of resident census bursing home shall be examined to examine the examined to the hundred ecarried to the hundred ecarried to the hundred ecarried to the hundred examined to examine the examined to the hundred ecarried to the hundred examined	of suant staff of the thorough the thorough the tempt to so for date the thorough	S 560	social media websites. Incentives are offered to CNA's to work extra shifts. Incentives are being offered for refer nursing employee as well as a sign of bonus for new hires. The facility has started a monthly raffle for nursing employees with a good attendance of the facility has partnered with additional staffing agencies. The facility has partnered with a CNA school in an eleberable to recruit the students once thave completed their certification. 4. The Administrator/designee will rethe staffing schedule weekly x 4 thermonthly x 3 to monitor the staffing rathe 7am - 3pm shift. The findings will reported to the QAPI committee mor 3 months.	ring a on ecord. onal fort to hey view of tio on libe

New Jersey Department of Health

STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		060713	B. WING		C 07/29/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
SINAI POS	ST ACUTE NURSING AN	ID REHAB CENTER 65 JAY S	TREET (, NJ 07103			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
S 560	midnight census for the begins. d. Nothing in this sect affect any minimum is nursing homes as machine Commissioner of Headers staff, including or restrict the ability of a staffing levels, at any established minimum. A review of "New Jer Long Term Care Asse Program Nurse Staff period beginning 6/20 revealed the facility with the State of New Jers requirements for 14 of 14	shall be based on the the day in which the shift stion shall be construed to staffing requirements for any be required by the alth for staff other than direct certified nurse aides, or to a nursing home to increase of time, beyond the normal sey Department of Health the sesment and Survey sing Report" for the 2-week 3/24 and ending 7/6/24 was not in compliance with sey minimum staffing of 14 day shifts. Sient in CNA staffing for a day shifts as follows: It is for 387 residents on the least 48 CNAs. It is for 387 residents on the least 48 CNAs. It is for 387 residents on the least 48 CNAs.	S 560	DEFICIENCY		
	day shift, required at	least 49 CNAs.				

New Jersey Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		060713	B. WING		07/2	; 9/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
SINAI POS	ST ACUTE NURSING AN	D REHAB CENTER 65 JAY ST NEWARK	REET NJ 07103				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
S 560	Continued From page	e 3	S 560				
		As for 393 residents on the					
	-06/29/24 had 32 CN day shift, required at	As for 393 residents on the least 49 CNAs.					
	-06/30/24 had 24 CN day shift, required at	As for 397 residents on the least 49 CNAs.					
	-07/01/24 had 34 CN day shift, required at	As for 392 residents on the least 49 CNAs.					
	-07/02/24 had 40 CN day shift, required at	As for 392 residents on the least 49 CNAs.					
	-07/03/24 had 47 CN day shift, required at	As for 392 residents on the least 49 CNAs.					
	-07/04/24 had 39 CN day shift, required at	As for 394 residents on the least 49 CNAs.					
	-07/05/24 had 41 CN day shift, required at	As for 394 residents on the least 49 CNAs.					
	-07/06/24 had 34 CN day shift, required at	As for 394 residents on the least 49 CNAs.					

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315236 _{Y1}	B. Wing	Y2	9/17/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
SINAI POST ACUTE NURSING AN	ID 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		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0550 483.10(a)(1)(2)(b)(Correction 1)(2) Completed 08/20/2024	ID Prefix Reg. # LSC	F0557 483.10(e)(2)	Correction Completed 08/20/2024	ID Prefix Reg. # LSC	F0561 483.10(f)(1)-(3)(8)	Correction Completed 08/20/2024
ID Prefix Reg. # LSC	F0603 483.12(a)(1)	Correction Completed 08/20/2024	ID Prefix Reg. # LSC	F0604 483.10(e)(1), 483.12(a) (2)	Correction Completed 08/20/2024	ID Prefix Reg. # LSC	F0679 483.24(c)(1)	Correction Completed 08/20/2024
ID Prefix Reg. # LSC	F0835 483.70	Correction Completed 08/20/2024	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction
REVIEWED BY STATE AGENCY (INITIALS) REVIEWED BY CMS RO (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON		DATE SIGNATURE OF S DATE TITLE CHECK FOR ANY UNCORRECTED			URVEYOR ED DEFICIENCIES. WAS A SUMMARY OF		DATE	
7/29/2024			LINGORDEGTED DEFICIENCIES (OMO OFOT) OFNIT TO THE FACILITY					YES NO

STATE FORM: REVISIT REPORT											
PROVIDER / SUPPLIER / CLIA / MULTIPLE CONST			TRUCTION					DATE O	FREVISIT		
IDENTIFICATION NUMBER 060713 A. Building B. Wing						Y2	9/17/2024 _{Y3}				
NAME OF FACILITY						STREET ADDRESS, CIT	Y, STATE, ZIP CO		<u> </u>		
SINAI PO	OST ACUTE NU	RSING AND	REHAB CEN	ΓER		65 JAY STREET					
						NEWARK, NJ 07103					
corrective	e action was acc tion prefix code p	omplished.	Each deficiend	cy should be full	y identified usi	reported that have beeing either the regulation es shown to the left of e	or LSC provision	number and	the		
ITEM DATE			DATE	ITEM		DATE ITEM			DATE		
Y4			Y5	Y4		Y5	Y4			Y5	
ID Prefix	S0560		Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg. #	8:39-5.1(a)		Completed	Reg. #		Completed	Reg. #			Completed	
LSC			08/20/2024	LSC			LSC _				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg.#			Completed	Reg. #		Completed	Reg. #			Completed	
LSC				LSC			LSC				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg.#			Completed	Reg. #		Completed	Reg.#			Completed	
LSC				LSC			LSC				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg.#			Completed	Reg. #		Completed	Reg.#			Completed	
LSC				LSC _			LSC				
ID Prefix			Correction	ID Prefix		Correction	ID Prefix			Correction	
Reg. #			Completed	Reg. #		Completed	Reg.#			Completed	
LSC				LSC			LSC				
REVIEWED BY STATE AGENCY (INITIALS)			DATE	SIGNATUR	RE OF SURVEYOR			DATE			
REVIEWED BY CMS RO (INITIALS)		DATE	TITLE				DATE				
FOLLOWUP TO SURVEY COMPLETED ON 7/29/2024				CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?							

Page 1 of 1 EVENT ID: SYPD12

7/29/2024