

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2024
NAME OF PROVIDER OR SUPPLIER  Sinai Post Acute Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 65 Jay Street Newark, NJ 07103	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605</b></p> <p>Complaint # NJ 175415</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that 11 of 11 Justice Involved Residents (JIR) were afforded the autonomy to participate in group activities, community dining, serving meals in a dignified manner, freely communicate with visitors, leave rooms at will and be free from physical restraints for (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11). The failure to treat residents respectfully and in a dignified manner had the likelihood to cause serious injury and psychological harm. This was cited as a pattern that immediately jeopardizes the health and safety of the JIR residents, as well as all other residents that reside in the facility which resulted in an IJ situation.</p> <p>The Immediate Jeopardy (IJ) began on 07/02/24, the date that the first JIR (Resident #1) was admitted to the facility and was secluded by law enforcement officers of the Bureau of Prison (BOP). The IJ was identified on 07/12/24, when Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11 were observed being secluded to their rooms, guarded by law enforcement officers, were not permitted to participate in group activities and community dining. Further observation revealed the JIRs were not allowed to intermingle or communicate with other residents or visitors and were restricted from leaving their rooms at will.</p> <p>The facilities Licensed Nursing Home Administrator (LNHA) was informed of the IJ on 07/12/24 at 3:49 PM, that an immediate jeopardy existed which also constituted Substandard Quality of Care (SQC) for 42 Code of Federal Regulations (CFR) 483.10 (a) (1). A facility must treat each resident with respect and dignity and care for each resident in a manner and an environment that promotes maintenance or enhancement of their quality of life and recognize each residents' individuality. The facility must protect and promote the rights of the resident.</p> <p>An acceptable removal plan was received on 7/29/24 at 9:59 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: All Justice Involved Residents were discharged from the facility as of 7/26/24. The facility will no longer admit Justice Involved Residents.</p> <p>The survey team verified the removal plan on-site on 7/29/24 and determined the IJ was removed as of 7/26/2024.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The findings were as follows:</p> <p>Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016 S &amp; C 16-21-ALL documented 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.</p> <p>The LNHA 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.</p> <p>The facility policy dated 02/2024 and titled, Resident Rights indicated that all residents would be treated equally regardless of age, race, sex, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The resident has a right to be treated with dignity and respect including being free from any physical or chemical restraints imposed for the purposes of discipline or convenience. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility . the right to receive visitors of his or her own choosing subject to the resident's right to deny visitation when applicable .right to participate in family groups .the right for personal privacy includes accommodations, medical treatment, telephone communications, personal care, visits and meetings of family and residents groups.</p> <p>1. According to the Admission Record, Resident #1 was admitted to the facility with diagnoses which included osteomyelitis (infection of the bone) of the right hand. According to the Admission assessment dated [DATE], Resident #1 was assessed as having no behaviors, and utilized no physical or chemical restraints. According to the Admission Progress note dated 07/02/24 at 3:20 PM, revealed the resident was alert and oriented. A review of the Individualized Care Plans (CP) revealed no care plans were initiated for the supervision of Activities of Daily Living (ADL) care, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #1 did not sign the facility Admission Agreement (AA). The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>2. According to the Admission Record Resident #2 was admitted to the facility with diagnoses which included multiple sclerosis (autoimmune disease). According to the Admission assessment dated [DATE], Resident #2 was assessed as having no behaviors, and utilized no physical or chemical restraints. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #2 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. According to the Admission Record Resident #3 was admitted to the facility with diagnoses which included polyneuropathy (peripheral nerve damage). According to the Admission assessment dated [DATE], Resident #3 was assessed as having no behaviors, and utilized no physical or chemical restraints. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #3 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>4. According to the Admission Record Resident #4 was admitted to the facility with diagnoses which included polyneuropathy. According to the Admission assessment dated [DATE], the resident was assessed as having no behaviors and utilized no physical or chemical restraints. The Admission Assessment indicated the resident was independent in their decision-making. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. According to the Admission summary progress note dated 07/02/24 at 1:37 PM, revealed the resident was alert and oriented. Further review of the medical record revealed that Resident #4 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>5. According to the Admission Record, Resident #5 was admitted to the facility with diagnoses which included local infection of the skin and subcutaneous tissue. According to the Admission assessment dated [DATE], the resident was assessed as having no behaviors and utilized no physical or chemical restraints. According to an Interdisciplinary progress note dated 07/10/24, revealed the resident was alert and verbally responsive. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #5 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>6. According to the Admission Record Resident #6 was admitted to the facility with diagnoses which included polyneuropathy. According to the Admission assessment dated [DATE], the resident was assessed as having no behaviors and utilized no physical or chemical restraints. According to the Social Service progress note dated 07/03/24 at 9:45 PM, resident #6 was assessed as alert and oriented with a Brief Interview for Mental Status of 15 out of 15, indicating that the resident had an intact cognition. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #6 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>7. According to the Admission Record Resident #7 was admitted to the facility with diagnoses which included low back pain. According to the Admission assessment dated [DATE], the resident was assessed as having no behaviors and utilized no physical or chemical restraints. According to the Admission summary note dated 07/04/24 at 11:12 AM, revealed the resident was alert, and able to verbalize their needs to staff. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #7 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>8. According to the Admission Record Resident #8 was admitted to the facility with diagnoses which included dilated cardiomyopathy (disease of the heart muscle). According to the Admission assessment dated [DATE], the resident was assessed as having no behaviors and utilized no physical or chemical restraints. According to the Admission progress note dated 07/09/24 at 2:40 PM, revealed the resident was alert, responsive and able to make their needs known. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #8 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>9. According to the Admission Record Resident #9 was admitted to the facility with diagnoses which included dementia. According to the Admission assessment dated [DATE], the resident was assessed as having no behaviors and utilized no physical or chemical restraints. According to the Admission progress note dated 07/10/24 at 1:36 PM, revealed the resident was alert with periods of forgetfulness. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #9 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>10. According to the Admission Record Resident #10 was admitted to the facility with diagnoses which included clostridium difficile colitis (C. diff) (bacterial infection of the colon). According to the Admission assessment dated [DATE], the resident was assessed as having no behaviors and utilized no physical or chemical restraints. The Admission summary progress note dated 07/02/24 at 2:40 PM, revealed the resident was alert and oriented x [times] 3 and able to make their own decisions. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #10 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>11. According to the Admission Record Resident #11 was admitted to the facility with diagnoses which included polyneuropathy. According to the Admission assessment dated [DATE], the resident was assessed as having no behaviors and utilized no physical or chemical restraints. According to the progress note dated 07/08/24 at 4:08 PM, revealed the resident was alert verbally responsive and able to make their needs known. A review of the CP revealed no CP were initiated regarding supervision with ADLs, restraints, activities, or seclusion. Further review of the medical record revealed that Resident #11 did not sign the facility AA. The Comprehensive Minimum Data Set (MDS) was in progress and unavailable for review.</p> <p>On 07/11/24 at 10:30 AM, resident interviews were attempted by surveyor #1 and #2, and was prohibited by the law enforcement officers. A supervisor of the U.S. Marshall's was interviewed and stated that all justice involved residents required approval by the U.S. Attorney's office or judge to have interviews or visitation.</p> <p>On 07/11/24 at 11:05 AM, Surveyor #2 was allowed by the prison guard to interview Resident #4 who stated they were not allowed to shower unless supervised by a prison guard. The resident stated that they had to eat meals in their room with disposable utensils and was secluded to the room and not allowed to intermingle with other residents. Resident #4 stated that they could only talk on the phone privately if speaking with their lawyer, otherwise they had to be supervised.</p> <p>On 07/11/24 at 11:12 AM, Surveyors #1 and #2 interviewed Resident #1, who stated that they had to eat their meals inside the room and was only allowed to leave the room for showers.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 07/11/24 at 11:42 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Social Work (DSW) who stated that she had been employed by the facility for about one year. She 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 residents. She explained the process of completing an advanced directive, discharge planning and held Care Plan meetings. She stated that when the JIR 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 in the room guarded and not being able to freely leave the room was a form a resident seclusion. She stated that the JIR residents were being isolated for safety reasons and that that was against the federal regulations.</p> <p>On 07/12/24 at 09:30 AM, Surveyors #3, #4, and #5 interviewed the 3rd floor Licensed Practical Nurse Unit Manager (LPN/UM), who stated the JIRs are served all their meals on disposable plates, utensils and cups as well as having their meals checked by the prison guards prior to serving. The LPN/UM further stated the JIR's shower schedule was Tuesday and Thursday in the evening and the prison guards stayed in the shower room with the JIR.</p> <p>On 07/12/24 at 09:40 AM, Surveyors #3 and #5 attempted resident interviews with Resident #8 and #9, but were told by the prison guard that interviews were not permitted but the surveyors could observe the JIRs through the doorway of their rooms. Surveyor #5 observed Resident #8's breakfast meal tray on the bedside table, the resident's meal was served on a disposable tray with paper plates, cups, and utensils. Resident #8 was observed in the room in wheelchair with an ankle restraint connected by a chain to the resident's bed. Resident #9 was observed in bed with an ankle restraint connected by a chain to the resident's bed.</p> <p>At that time, the surveyors observed that the non JIRs on the unit were utilizing non disposable trays, and regular dishware (plates, cups and utensils).</p> <p>On 07/12/24 at 09:45 AM, Surveyor #5 interviewed the Licensed Practical Nurse (LPN #1) who was the nurse for both Resident #8 and #9. LPN #1 stated the JIRs stay in their rooms all day except on shower days. LPN #1 stated the JIRs do not participate in group activities, go into the main dining area, and did not believe they were allowed visitors.</p> <p>On 07/12/24 at 10:10 AM, Surveyor #5 reviewed the electronic medical record (EMR) for Resident #8 and #9. Resident #8 had a Physician Order (PO) with a start date of 7/8/24 for, recreation as tolerated. Resident #9 had a PO with a start date of 7/5/24 for, recreation as tolerate. However, further review of the medical record revealed there was no documented recreation screen/assessment, notes or care plans for Resident # 8 and #9.</p> <p>NJAC 8:39-4.1(a) 11</p>		

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 37175</p> <p>Complaint # NJ 175415</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents were treated in a dignified and respectful manner 11 of 11 Justice Involved Residents (JIR) by physically restraining, secluding the residents from participating in group activities, community dining, intermingling with other residents, communicating with visitors and leaving the room at will. This was cited as a pattern that immediately jeopardizes the health and safety of the JIR residents, as well as all other residents that reside in the facility which resulted in an Immediate Jeopardy (IJ) situation.</p> <p>The Immediate Jeopardy (IJ) began on 07/02/24, the date that the first JIR (Resident #1) was admitted to the facility and was secluded to the room by law enforcement officers of the Bureau of Prison [BOP]. The IJ situation was identified on 07/12/24, when Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11 were observed being secluded to their rooms guarded by law enforcement officers, not permitted to participate in group activities and community dining, being served meals in a dignified manner, intermingling with other residents, communicating with visitors, and leaving the room at will.</p> <p>The facilities Licensed Nursing Home Administrator (LNHA) was informed of the IJ situation on 07/12/24 at 3:49 PM, that an immediate jeopardy situation existed.</p> <p>An acceptable removal plan was received on 7/29/24 at 9:59 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: All Justice Involved Residents were discharged from the facility as of 7/26/24. The facility will no longer admit Justice Involved Residents.</p> <p>The survey team verified the removal plan on-site on 7/29/24 and determined the IJ was removed as of 7/26/2024.</p> <p>The findings were as follows:</p> <p>Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016 S &amp; C 16-21-ALL, documented 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.</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of a facility policy titled Resident Rights dated 02/2024, included under Policy Explanation and Compliance Guidelines that prior to or upon admission, the social service designee, or another designated staff member, will inform the resident of the resident's rights and responsibilities. 2. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 5. Respect and Dignity. The resident has a right to be treated with respect and dignity including the right to be free of any physical or chemical restraint . 6. Self-determination. The resident has the right to, and the facility must promote and facilitate residents' self-determination through support of resident's choice, including but not limited to the right to choose activities, make choices about aspect of his or her life, right to interact with members of the community both inside and outside the facility, and the right to receive visitors. 7. Information and communication. The resident has the right to be informed of his or her rights and of all the rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. 8. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment written and telephone communication, personal care, visits, and meetings of family and resident groups.</p> <p>The surveyor reviewed Resident # 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11's medical records.</p> <p>1. Review of the Admission Record (AR), Resident # 1 was admitted to the facility with diagnoses which included but was not limited; to osteomyelitis (infection of the bone) of the right hand.</p> <p>Review of an Admission progress note dated 07/02/2024 at 3:20 PM, revealed that Resident #1 was alert and oriented.</p> <p>Review of the Admission Assessment (AA) dated 07/02/2024, Resident #1 was assessed as not having any behaviors or required physical or chemical restraints, however Resident #1 was observed by Surveyor #1 and Surveyor #2 on 07/11/24 at 11:04 AM, wearing metal ankle cuffs.</p> <p>There were no consents for the use of metal ankle cuffs.</p> <p>Review of the physician's orders (PO) reflected that there were no orders for the use of metal ankle cuffs, however a PO order dated 07/02/24, reflected an order to monitor skin integrity under the cuff area every shift.</p> <p>Review of the resident's Individualized Care Plans (CP) dated 07/02/24, which revealed that a CP was not implemented for the use of restraints. The CP did not address that the resident required constant supervision from the detention guards for all aspects of activities of daily living (ADLs). The CP did not address that the resident was not permitted to leave the room unless for showering and accompanied by the detention guards and there was no documentation on the CP to address restrictions from attending community activities and community dining.</p> <p>A comprehensive Minimum Data Set (MDS) and assessment tool that facilitates a resident's care, was not yet completed.</p> <p>Resident #1 did not sign the facility Admission Agreement,a contract which included all documents that a resident or responsible person must sign at the time of, or as a condition of, admission).</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the AA dated 07/02/2024, revealed the resident was assessed as not having any behaviors, was independent with their decision-making, and required no physical or chemical restraints. A review of the admission summary progress note dated 07/02/24 at 01:37 PM, the resident was alert and oriented.</p> <p>Review of the resident's individualized comprehensive care plan date initiated 07/02/24, did not include any indicate focus areas that would address supervision from law enforcement with Activities of daily living, restraints, activities, or seclusion.</p> <p>Review of the order Summary Report revealed a physician order (PO) dated 7/11/24, to check the skin integrity on bilateral ankle cuffs every shift. Further review revealed that there were no orders for restraints and seclusion from the rest of the facility with continuous monitoring from law enforcement.</p> <p>Review of the MDS revealed a comprehensive MDS was not yet completed.</p> <p>Further review of the medical record revealed that Resident #4 did not sign the facility Admission agreement.</p> <p>5. According to the AR, Resident #5 was admitted to the facility with diagnoses which included but not limited to; local infection of the skin and subcutaneous tissue.</p> <p>Review of the AA dated 07/03/24, revealed that the resident was assessed as not having any behaviors or required physical or chemical restraints.</p> <p>A review of the Care Plan initiated on 07/03/24, revealed no Care Plans were initiated regarding supervision with Activities of Daily Living restraints, activities, or seclusion.</p> <p>Review of an Interdisciplinary progress note dated 07/10/24, revealed that Resident # 5 was alert and verbally responsive.</p> <p>Review of the Minimum Data Set revealed a comprehensive MDS was not yet completed.</p> <p>Further review of the medical record revealed that Resident #5 did not sign a facility Admission Agreement.</p> <p>6. According to the AR; Resident # 6 was admitted to the facility on [DATE] with diagnoses which included but not limited to; polyneuropathy.</p> <p>Review of the AA dated 07/03/24, revealed that the resident was assessed and did not have any behaviors or required physical or chemical restraints.</p> <p>Review of the Care Plan initiated on 07/03/24, revealed no Care Plans were initiated regarding supervision with ADLs, restraints, activities, or seclusion.</p> <p>Review of the MDS revealed a comprehensive MDS was not yet completed.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Sinai Post Acute Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  65 Jay Street Newark, NJ 07103	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Further review of the medical record revealed that Resident #6 did not sign a facility Admission Agreement.</p> <p>7. According to the AR, Resident # 7 was admitted to the facility on [DATE] with diagnoses which included but not limited to; low back pain.</p> <p>Review of the AA dated 07/04/24, revealed that the resident was assessed as not having any behaviors or required physical or chemical restraints.</p> <p>Review of a progress note dated 07/04/24, revealed that Resident #7 was alert and oriented.</p> <p>Review of the Care Plan initiated 07/04/24, revealed no Care Plans were initiated regarding supervision with Activities of Daily Living, restraints, activities, or seclusion.</p> <p>Review of the MDS revealed a comprehensive MDS was not yet completed.</p> <p>Further review of the medical record revealed that Resident #7 did not sign a facility Admission Agreement.</p> <p>8. According to the AR, Resident #8 was admitted to the facility on [DATE] with diagnoses which included but not limited to; dilated cardiomyopathy (disease of the heart muscle).</p> <p>Review of the AA dated 07/08/24, revealed revealed that the resident was assessed as not having any behaviors or required physical or chemical restraints.</p> <p>Review of the Care Plan initiated on 07/08/24, no Care Plans were initiated regarding supervision with Activities of Daily Living, restraints, activities, or seclusion.</p> <p>Review of a progress note dated 07/09/24, revealed that Resident #8 was alert and verbally responsive.</p> <p>Review of the MDS revealed a comprehensive MDS was not yet completed.</p> <p>Further review of the medical record revealed that Resident # 8 did not sign a facility Admission Agreement.</p> <p>9. According to the AR, Resident #9 was admitted to the facility with diagnoses which included but was not limited to dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement).</p> <p>Review of the AA dated 7/5/2024, revealed the resident was assessed as having no behaviors and required no physical or chemical restraints, however on 07/11/24 at 10:43 AM, Surveyor #1 and Surveyor #2 observed the resident in the room with metal cuff affixed to both ankles.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of the CP dated 07/05/24, revealed that a CP was not implemented for the use of restraints. The CP did not address that the resident required constant supervision from the detention guards for all aspects of activities of daily living (ADLs). The CP did not address that the resident was not permitted to leave the room unless for showering and accompanied by the detention guards and there was no documentation on the CP to address restrictions from attending community activities and community dining.</p> <p>Review of the progress admission note dated 07/10/2024 at 1:36 PM, revealed that the resident was alert with periods of forgetfulness.</p> <p>Review of the physician's orders (PO) reflected that there were no orders for the use of metal ankle cuffs, however the PO reflected an order dated 07/11/24, to check skin integrity under on bilateral ankle cuffs every shift.</p> <p>There were no consents found in the EMR regarding the use of ankle restraints.</p> <p>Review of the MDS revealed a comprehensive MDS was not yet completed.</p> <p>Further review of the medical record revealed that Resident #9 did not sign a facility Admission Agreement.</p> <p>10. According to the AR, Resident #10 was admitted on [DATE], and had diagnoses which included but not limited to; enterocolitis due to clostridium Difficile (inflammation of the digestive tract due to an infection), depression, anxiety disorder, and diverticulitis (inflammation or infection in digestive tract).</p> <p>Review of the admission summary progress note dated 07/02/24 at 2:40 PM, revealed the resident was alert and oriented x3 and was able to make their own decisions</p> <p>Review of the order Summary Report revealed physician orders (PO) dated 07/02/24, revealed no order for restraints or seclusion from the rest of the facility with continuous monitoring from law enforcement.</p> <p>Review of the resident's individualized comprehensive care plan date initiated 07/02/24, did not indicate focus areas that would address supervision of law enforcement with Activities of daily living, restraints, activities, or seclusion.</p> <p>Review of the MDS revealed a comprehensive MDS was not yet completed.</p> <p>Further review of the medical record revealed that Resident #10 did not sign a facility Admission Agreement.</p> <p>11. Review of the AR indicated that Resident #11 was admitted to the facility with diagnoses which but was not limited to; polyneuropathy (Damage to multiple peripheral nerves).</p> <p>Review the AA dated 07/03/24, revealed the resident was assessed as not having any behaviors and did not require physical or chemical restraints, however Resident #11 was observed by Surveyor #1 and Surveyor #2 on 07/11/24 at 10:44 AM, wearing metal ankle cuffs.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of the CP dated 07/03/24 revealed that a CP was not implemented for the use of restraints. The CP did not address that the resident required constant supervision from the detention guards for all aspects of activities of daily living (ADLs). The CP did not address that the resident was not permitted to leave the room unless for showering and accompanied by the detention guards and there was no documentation on the CP to address restrictions from attending community activities and community dining.</p> <p>According to the progress note (PN) dated 07/08/24 at 4:08 PM, the resident was alert verbally responsive and able to make their needs known.</p> <p>Review of the physician's orders (PO) reflected that there were no orders for the use of metal ankle cuffs, however the TAR reflected an order dated 07/11/24, to check skin integrity under bilateral ankle cuffs every shift.</p> <p>On 07/11/24 at 09:00 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Nursing (DON) who stated that she was notified by the facilities Cooperate Offices (CO) that JIRs were entering the facility. She stated that the facilities CO instructed the facilities administration (DON, Administrator, Admission Coordinator, Social Services, Activities Director, and Unit Managers) not to mix the JIR with other residents and that they needed to be roomed together. She stated that the JIRs would be guarded by law enforcement and their ankles would be shackled with metal cuffs. She stated that the CO also instructed the facility not to mix or intermingle the JIR with other residents in the facility.</p> <p>On 07/11/2024 at 09:35 AM, Surveyor #1 and #2 interviewed the Minimum Data Set Coordinator (MDSC) who stated that the eleven (11) JIRs had entry MDSs completed, however comprehensive MDSs were not completed until day 14 of admission. The MDSC provided the surveyors with the entry MDSs for all 11 JIRs.</p> <p>On 07/11/2024 at 10:20 AM, Surveyor #1 and Surveyor #2 toured the fourth floor and interviewed Licensed Practical Nurse (LPN#1) who stated that he worked for an agency and that it was his first time working at the facility. LPN #1 stated that there were 6 (six) JIRs residing on his unit (Resident #2, 5, 6, 8, 9, and 11). He stated that there were police officers guarding the residents and that the residents wore metal ankle cuffs. He continued to explain that he was not sure what the residents' limitations were and was not aware of any behaviors that the JIRs had. He also added that he was not aware of any complaints about these residents from other residents that resided on his unit.</p> <p>On 07/11/2024 at 10:25 AM, Surveyor #1 observed the JIRs from the hallway. The six residents that resided on the fourth floor were observed in their rooms being guarded by law enforcement officers.</p> <p>On 07/11/24 at 10:30 AM, resident interviews were attempted by Surveyor #1 and #2, and was prohibited by the law enforcement officers.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>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 Supervisor of the United States Marshalls (SUSM) (federal law enforcement agency in the United States, enforcing the federal courts). He stated that the surveyors were not allowed to enter the JIRs rooms and would not allow the surveyors to interview the JIRs on the 4 (four) [NAME] Unit (Resident #2, 5, 6, 8, 9, and 11). The SUSM explained to Surveyor #1 and Surveyor #2 that the JIRs were at the facility for rehabilitation services. He stated that all JIRs were to wear metal ankle restraints, and all were to be chained to the bed. 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 other JIR residents. He stated that the JIR residents could only leave their rooms with escorts for showering or any other reason which was approved by the U.S Marshals. He stated that the JIRs must eat in their rooms and could not eat in the main dining room with the other residents. He stated that visitation of anyone must be approved by US Attorney or Judge.</p> <p>On 07/11/2024 at 10:42 AM, Surveyor #1 observed Resident #5 and #6 from the hallway lying in bed guarded by 3 (three) detention officers, wearing metal ankle restraints that were chained to the bed.</p> <p>On 07/11/2024 at 10:43 AM, Surveyor #1 observed from the hallway Resident #8 and #9 being guarded to the room by 3 detention officers and chained with metal ankle restraints.</p> <p>On 07/11/2024 at 11:00 AM, Surveyor #1 and Surveyor #2 toured the 3rd floor Unit. The surveyor interviewed LPN #2 who stated that there were three (3) JIRs on the unit (Resident #1, #4 and #10).</p> <p>A supervisor of the U.S. Marshalls was interviewed and stated that all justice involved residents required approval by the U.S Attorney's office or judge to have interviews or visitation.</p> <p>On 07/11/24 at 11:05 AM, Surveyor #1 and Surveyor #2 were given permission from the detention officer to interview Resident #4 who was observed in bed. The surveyor observed that the Resident #4 was wearing plastic ankle restraints. The guard in the room indicated that the resident had medical issues and was required to wear the plastic restraints (ankle cuffs) instead of metal. The surveyors observed the plastic ankle cuffs were shackled with a metal chain to the bed. Resident #4 stated that they were in the facility due to heart and vascular problems. The resident stated that food was good, used disposable utensils to eat meals, and that they were not allowed to leave the room, only for a shower which was supervise by a prison guard. The resident stated that they were not allowed to intermingle with other residents and were only able to talk on the phone privately with their attorney. Resident #4 stated that otherwise there was no privacy when speaking on the phone.</p> <p>On 07/11/2024 at 11:12 AM, Surveyor #1 and Surveyor #2 were given permission from the detention guard to interview Resident #1, who was cognitively intact. The resident stated that he/she was admitted to the facility with the diagnoses of osteomyelitis and colitis and needed intravenous antibiotic therapy. Resident #1 stated that they received meals in the room but was able to pick his/her own meals and that the facility honored food preferences. The resident stated that he/she had not left the room except for showering. The resident stated that this was the only time that he/she could leave the room.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>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 6th floor and had the diagnoses of Methicillin Resistant Staphylococci Aureus (MRSA) in the right axilla (armpit) and was on oral antibiotics. She also identified the resident as a prisoner. She stated that Resident #3 was not allowed to come out of the room unless it was to shower and had to eat meals in the room. She stated that the resident had activities in the room but was not allowed to attend activities in the main activity room because there was no intermingling with prisoners and LTC residents. LPN/UM #1 stated that Resident #7 also resided on the 6th floor and had a history of back pain. She stated that Resident #7's restrictions were the same as Resident #3.</p> <p>On 07/11/2024 at 11:35 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Recreation (DOR) who stated that she was informed by the Licensed Nursing Home Administrator (LNHA) that when the JIR were 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. She stated that she provided the JIR residents with a basket of puzzles and cards on admission, however the residents were not to attend any activities out of their rooms.</p> <p>On 07/11/24 at 11:42 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Social Work (DSW) who stated that she had been employed by the facility for about 1 (one) year. She 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. She stated that when the JIR 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 in the room guarded and not being able to freely leave the room was a form of resident seclusion. She stated that the JIR residents were being isolated for safety reasons and that that was against the federal regulations.</p> <p>On 07/11/24 at 12:20 PM, during an interview with Surveyor # 1 the LNHA stated that shackles were considered a restraint. Further, he confirmed that seclusion, restriction of visitors, being served food with plastic and paper products and requiring supervision 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 intermingle with other residents, then that would be a form of seclusion.</p> <p>On 07/12/2024 at 9:15 AM, Surveyor #3, #4, and #5 toured the third floor and observed armed guards standing in the hallway near Resident #1, Resident #4 and Resident #10's rooms. Further observation revealed that there were armed guards standing inside the rooms. Surveyor # 4 observed residents #4 and #10 from the hallway, the names on the door were not the names of the residents identified as Resident #4 and #10 in the beds. The residents were observed to be covered with blankets and the guards prevented the surveyor from entering the rooms and from interviewing the residents.</p> <p>On 07/12/2024 at 9:18 AM, Surveyor #4 interviewed Licensed Practical Nurse #2 (LPN #2), who stated she could give the residents medication and the guards would identify the justice involved residents (JIR), and the guards would watch her give the medication to the residents. LPN #2 further stated that there were always two guards present, and one guard would observe the nursing care and staff was not allowed to pull the curtain to provide privacy. She further stated that she and all the staff are supervised by the Feds.</p> <p>(continued on next page)</p>

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 07/12/2024 at 9:30 AM during an interview with Surveyor # 3 and # 5, Unit Manager # 3 confirmed that the JIRs stay in their rooms. Further, she confirmed that the JIRs received disposable trays for their meals. Lastly, she confirmed that they only come out of their rooms for showers on Tuesday and Thursday evenings.</p> <p>On 07/12/2024 at 9:30 AM, Surveyor #4 interviewed an unsampled resident who stated that they were aware there are prisoners at the facility and the prisoners do not come out of their rooms and do not participate in activities with other residents.</p> <p>On 07/12/2024 at 09:34 AM, Surveyor #1 and Surveyor #2 interviewed the LNHA who stated that the facility could accommodate the JIRs medical needs, however after he received the Centers for Medicare and Medicaid Services (CMS) memo S &amp; C: 16-21-ALL, with a revised date 12/23/2016, he understood that it was against federal regulation to restrain or seclude the JIRs. He stated that he called the nursing home in New York to inform them to stop sending the JIRs 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 JIR residents had nowhere else to go. He then stated that it was not the facility that was imposing these restrictions on the JIRs, it was the Bureau of Prisons that was imposing them. He added that the facility was aware that the JIRs were being treated differently by the facility than the regular facility residents and that it was not the facilities standard of practice, however he felt that the Department of Justice (DOJ) was a strong governing body and that he was between the Department of Health and the DOJ.</p> <p>On 07/12/24 at 09:40 AM, Surveyors #3 and #5 attempted resident interviews with Resident #8 and #9, but were told by the prison guard that interviews were not permitted but the surveyors could observe the JIRs through the doorway of their rooms. Surveyor #5 observed Resident #8's breakfast meal tray on the bedside table, the resident's meal was served on a disposable tray with paper plates, cups, and utensils. Resident #8 was observed in the room in wheelchair with an ankle restraint connected by a chain to the resident's bed. Resident #9 was observed in bed with an ankle restraint connected by a chain to the resident's bed.</p> <p>On 07/12/24 at 09:40 AM, Surveyors #3, #4, and #5 interviewed the 3rd floor Licensed Practical Nurse Unit Manager (LPN/UM), who stated the JIRs were served all their meals on disposable plates, utensils and cups as well as having their meals checked by the prison guards prior to serving. The LPN/UM further stated the JIR's shower schedule was Tuesday and Thursday in the evening and the prison guard stayed in the shower room with the JIR.</p> <p>On the same date at 9:43 AM while observing the fourth floor, Surveyor # 3 observed Resident # 5 and Resident # 6 from the hallway while they were in the room. The room contained two guards. No resident names were identified on the door placard. Resident # 6 was in bed. A metal chain was observed hanging below the sheet of the bed.</p> <p>On 07/12/2024 at 09:45 AM, Surveyor #5 interviewed the Licensed Practical Nurse (LPN #1) who is the nurse for both Resident #8 and #9. LPN #1 stated the JIRs stayed in their rooms all day except on shower days. LPN#1 stated the JIRs did not participate in group activities, go into the main dining area, and did not believe they were allowed visitors.</p> <p>On the same date at 9:50 AM, Surveyor # 3 interviewed an unsampled resident who stated that they had no interaction with the JIRs.</p> <p>(continued on next page)</p>		

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<p>F 0557</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 07/12/2024 at 12:15 PM, Surveyor #1 and Surveyor #2 interviewed LNHA who stated that residents being secluded to their room, secluded from other residents, and not being able to attend activities or eat in the main dining rooms were all a form of seclusion, however it was not the LNHA that was enforcing this on the JIR residents, it was the Bureau of Prisoners.</p> <p>On 07/12/24 at 1:24 PM, Surveyors #1, #2, #3, #4, and #5 conducted a phone interview with the Medical Director (MD) who stated that he had been on vacation when the 11 JIRs were admitted to the facility. He stated he was not aware that the 11 JIRs were secluded to their rooms or that they were all restrained with ankle shackles. The MD further stated that he did not write physician orders for restraints for any of the 11 JIRs.</p> <p>On 07/12/24 at 3:40 PM, Surveyors #2, #3, #4 and #5 met with the LNHA, Regional DON, and the DON and were notified of the IJ and were provided with the IJ template.</p> <p>On 07/15/2024 at 8:45 AM, while on the third floor, Surveyor # 3 observed Resident # 4 from the hallway. The guard would not allow the surveyor to enter the room. At that time, Surveyor # 3 observed a metal shackle affixed to the resident's leg and to the bed. One guard was observed within the room. Also at that time, Surveyor # 3 observed Resident # 10 in bed. A metal shackle was observed affixed to the bed. Also, one guard was present in that room.</p> <p>On the same date at 8:51 AM, while on the fourth floor, Surveyor # 3 observed Resident # 6 and Resident # 5 in their rooms. They had metal chains hanging from their beds.</p> <p>On 07/15/24 at 09:44 AM, Surveyor #2, #3 and #5 interviewed the LNHA who stated until he met with or heard from the New Jersey Department of Health (NJDOH), Centers of Medicare and Medicaid (CMS), and the [contracted company] that he could not submit a removal plan for any of the deficiencies because the prisoners could not be released into the facility and would have to be removed from the facility.</p> <p>On 07/15/24 at 9:45 AM during an interview with the Surveyor #2 and #3, the Licensed Nursing Home Administrator confirmed that the 11 JIRs involved residents were still being secluded and still being restrained.</p> <p>NJAC 8:39-4.1</p> <p>&lt;b [TRUNCATED]</p>

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<p>F 0561</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43936</p> <p>Complaint # NJ 175415</p> <p>Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to promote and facilitate 11 of 11 Justice Involved Residents' (JIR) (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) right to: 1) make their own choices regarding aspects of their life and care; 2) participate in activities and 3) interact with members of the community both inside and outside the facility. The failure to promote and facilitate a resident's self-determination had the likelihood to cause serious psychological harm.</p> <p>On 07/11/24 at 09:00 AM, Surveyor #1 and #2 interviewed the Director of Nursing (DON) who stated that she was notified by the facility's Corporate Office (CO) that JIRs were entering the facility. The DON stated that the CO instructed the facility's administration (DON, Administrator (LNHA), Admission Coordinator, Social Services, Activities Director, and Unit Managers) that all JIRs would be shackled, guarded by law enforcement officers from the Bureau of Prison [BOP], and were not to interact with other residents.</p> <p>On 07/11/24 at 11:35 AM, Surveyor #1 interviewed the Director of Recreation who stated that she was informed by the Interdisciplinary Team and the LNHA that no activity assessment had to be completed for the JIRs because the JIRs would not be attending any activities.</p> <p>On 07/12/24 at 9:30 AM, Surveyor #3 and #5 interviewed Unit Manager (UM) #3 who stated that the JIRs stayed in their rooms. UM3 stated that the JIRs only come out of their rooms for showers on Tuesday and Thursday evenings.</p> <p>The facility's LNHA was informed of the Immediate Jeopardy (IJ) situation on 07/12/24 at 3:49 PM which also constituted Substandard Quality of Care (SQC) for 42 Code of Federal Regulations (CFR) S483.10(f)(1)(2)(3)(8). The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.</p> <p>An acceptable removal plan was received on 7/29/24 at 9:59 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: All Justice Involved Residents were discharged from the facility as of 7/26/24. The facility will no longer admit Justice Involved Residents.</p> <p>The survey team verified the removal plan on-site on 7/29/24 and determined the IJ was removed as of 7/26/2024.</p> <p>The findings were as follows:  (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2024
NAME OF PROVIDER OR SUPPLIER  Sinai Post Acute Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  65 Jay Street Newark, NJ 07103	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0561</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>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&amp;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.</p> <p>The facility policy dated 02/2024 and titled, Resident Rights indicated that all residents would be treated equally regardless of age, race, sex, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The resident has a right to be treated with dignity and respect including being free from any physical or chemical restraints imposed for the purposes of discipline or convenience. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility . the right to receive visitors of his or her own choosing subject to the resident's right to deny visitation when applicable .right to participate in family groups .the right for personal privacy includes accommodations, medical treatment, telephone communications, personal care, visits and meetings of family and residents groups.</p> <p>Review of a facility policy titled Care Plan with a review date of April 2024 revealed under, Policy that, It is the policy of [NAME] that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner.</p> <p>Review of a facility policy titled, Activity Programs with a revised date of February 2024 revealed under, Policy Interpretation and Implementation that, 1. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs.</p> <p>On 07/11/24 at 11:05 AM, Surveyor #1 and #2 were given permission from the law enforcement officer to interview Resident #4. Resident #4 stated they could only leave the room to shower, could not intermingle with other residents and were only able to talk on the phone privately with their attorney. Resident #4 stated that otherwise there was no privacy when speaking on the phone.</p> <p>The surveyors attempted to interview other JIRs but were denied by the law enforcement officers.</p> <p>The survey reviewed the medical records.</p> <p>1. According to the Admission Record (AR), Resident #1 was admitted with diagnoses which included but not limited; to Osteomyelitis (an infection of the bone) of the right hand.</p> <p>Review of an admission progress note dated 07/02/24 at 3:20 PM, revealed Resident #1 was alert and oriented.</p> <p>2. According to the AR, Resident #2 was admitted with the diagnoses which included but not limited to; Multiple Sclerosis (an autoimmune disease).</p> <p>3. According to the AR, Resident #3 was admitted with diagnoses which included but not limited to polyneuropathy (peripheral nerve damage).</p> <p>Review of a progress note dated 07/05/24, revealed Resident # 3 was alert and verbally responsive.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>4. According to the AR, Resident #4 was admitted with diagnoses which included but not limited to; polyneuropathy.</p> <p>The admission assessment documented Resident #4 was independent in decision-making.</p> <p>5. According to the AR, Resident #5 was admitted with diagnoses which included but not limited to; local infection of the skin and subcutaneous tissue.</p> <p>Review of an Interdisciplinary progress note dated 07/10/24, revealed Resident #5 was alert and verbally responsive.</p> <p>6. According to the AR, Resident #6 was admitted with diagnoses which included but not limited to; polyneuropathy.</p> <p>Review of a Social Service progress note dated 07/03/24 at 9:45 PM, revealed Resident #6 was alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15 at of 15 indicating that the resident's cognition was intact.</p> <p>7. According to the AR, Resident #7 was admitted with diagnoses which included but not limited to; low back pain.</p> <p>Review of an Admission summary note dated 07/04/24 at 11:12 AM, revealed Resident #7 was alert, and able to verbalize their needs to staff.</p> <p>8. According to the AR, Resident #8 was admitted with diagnoses which included but not limited to; dilated cardiomyopathy (a disease of the heart muscle).</p> <p>Review of an Admission progress note dated 07/09/24 at 2:04 PM, revealed Resident #8 was alert, responsive and able to make their needs known.</p> <p>9. According to the AR, Resident #9 was admitted with diagnoses which included but not limited to; dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement).</p> <p>Review of a progress admission note dated 07/10/24 at 1:36 PM, revealed Resident #9 was alert with periods of forgetfulness.</p> <p>10. According to the AR, Resident #10 was admitted with diagnoses which included but not limited to; Clostridium Difficile Colitis (C. diff; a bacterial infection of the colon).</p> <p>Review of the admission summary progress note dated 07/02/24 at 2:40 PM, revealed Resident #10 was alert and oriented x 3 and able to make their own decisions.</p> <p>11. According to the AR, Resident #11 was admitted with diagnoses which included but not limited to; polyneuropathy.</p> <p>Review of a progress note date 07/08/24 at 4:08 PM, Resident #11 was alert, verbally responsive and able to make their needs known.</p> <p>(continued on next page)</p>

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<p>F 0561</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>A review of the Individualized Care Plans (ICP) for Resident #1 through #11 revealed no CPs were initiated addressing the resident's choices regarding the aspects of their life that were significant to the residents. Further review of the medical record revealed that Resident #1 through #11 did not sign the facility Admission Agreement. The comprehensive Minimum Data Sets (MDS) were in progress and unavailable for review.</p> <p>NJAC 8:39-27.1(a)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 33106</p> <p>Complaint # NJ 175415</p> <p>Based on observation, interview, review of resident medical records and other pertinent facility documentation it was determined that the facility failed to ensure that 11 of 11 Justice Involved Residents (JIRs) (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) were free from involuntary seclusion. The JIR were secluded from having autonomy and to make choices 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. The failure to allow JIRs autonomy posed the likelihood to cause serious injury, psychological harm, and severe mental anguish which resulted in an Immediate Jeopardy (IJ) situation.</p> <p>The IJ began on 07/02/2024, the date that the first JIR (Resident #1) was admitted to the facility and was secluded to the room by law enforcement officers of the Bureau of Prison [BOP]. The IJ situation was identified on 07/12/2024 when Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11 were observed being secluded to their rooms and guarded by law enforcement officers.</p> <p>The facility Licensed Nursing Home Administrator (LNHA) was informed of the IJ situation on 07/12/2024 at 3:49 PM which also constituted Substandard Quality of Care (SQC) for 42 Code of Federal Regulations (CFR) 483.12(a)(1). The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</p> <p>An acceptable removal plan was received on 7/29/24 at 9:59 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: All Justice Involved Residents were discharged from the facility as of 7/26/24. The facility will no longer admit Justice Involved Residents.</p> <p>The survey team verified the removal plan on-site on 7/29/24, and determined the IJ was removed as of 7/26/24.</p> <p>The findings are as follows:</p> <p>Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016, S &amp; C 16-21-ALL, documented 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.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility policy dated 02/2024 and titled, Resident Rights indicated that all residents would be treated equally regardless of age, race, sex, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The resident has a right to be treated with dignity and respect including being free from any physical or chemical restraints imposed for the purposes of discipline or convenience. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility . the right to receive visitors of his or her own choosing subject to the resident's right to deny visitation when applicable .right to participate in family groups .the right for personal privacy includes accommodations, medical treatment, telephone communications, personal care, visits and meetings of family and residents groups.</p> <p>On 07/11/2024 at 09:00 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Nursing (DON) who stated that she was notified by the facilities Cooperate Offices (CO) that JIRs were entering the facility. She stated that the facilities CO instructed the facilities administration (DON, Administrator, Admission Coordinator, Social Services, Activities Director, and Unit Managers) not to mix the JIR with other residents and that they needed to be roomed together. She stated that the JIRs would be guarded by law enforcement and their ankles would be shackled with metal cuffs. She stated that the CO also instructed the facility not to mix or intermingle the JIR with other residents in the facility, no community activities or outside visitation.</p> <p>On 07/11/2024 at 10:20 AM, Surveyor #1 and Surveyor #2 toured the fourth floor and interviewed Licensed Practical Nurse (LPN#1) who stated that he worked for an agency and that it was his first time working at the facility. LPN #1 stated that there were 6 (six) JIRs residing on his unit (Resident #2, #5, #6, #8, #9, and #11). He stated that there were police officers guarding the residents and that the residents wore metal ankle cuffs. He continued to explain that he was not sure what the residents' limitations were and was not aware of any behaviors that the JIRs had. He also added that he was not aware of any complaints about these residents from other residents that resided on his unit.</p> <p>On 07/11/2024 at 10:25 AM, Surveyor #1 observed the JIRs from the hallway. Residents #2, #5, #6, #8, #9 and #11, that resided on the fourth floor were observed in their rooms being guarded by law enforcement officers.</p> <p>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 Supervisor of the United States Marshals (SUSM) (federal law enforcement agency in the United States, enforcing the federal courts). He stated that the surveyors were not allowed to enter the JIRs rooms and would not allow the surveyors to interview the JIRs on the 4 (four) [NAME] Unit (Resident #2, #5, #6, #8, #9, and #11). The SUSM explained to the surveyors that the JIRs were at the facility for rehabilitation services. He stated that all JIRs were to wear metal ankle restraints, and all were to be chained to the bed. He explained that the 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 other JIR residents. He stated that the JIR residents could only leave their rooms with escorts for showering or any other reason which was approved by the U.S Marshals. He stated that the JIRs must eat in their rooms and could not eat in the main dining room with the other residents. He stated that visitation of anyone must be approved by US Attorney or Judge.</p> <p>On 07/11/2024 at 10:42 AM, Surveyor #1 observed Resident #5 and #6 from the hallway lying in bed guarded by 3 (three) detention officers, wearing metal ankle restraints that were affixed to the bed.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 07/11/2024 at 10:43 AM, Surveyor #1 observed Resident #8 and #9 from the hall, being guarded to the room by 3 detention officers and chained to the bed with metal ankle restraints.</p> <p>On 07/11/2024 at 11:00 AM, Surveyor #1 and Surveyor #2 toured the 3rd floor Unit. The surveyor interviewed LPN #2 who stated that there were three (3) JIRs on the unit (Resident #1, #4 and #10).</p> <p>On 07/11/2024 at 11:05 AM, Surveyor #1 and Surveyor #2 were given permission from the detention officer to interview Resident #4 who was observed in bed with glasses and was pleasant and cooperative. The surveyor observed that Resident #4 was wearing plastic ankle restraints. The guard in the room indicated that the resident had medical issues and was required to wear the plastic restraints (ankle cuffs) instead of metal. The surveyors observed the plastic ankle cuffs were shackled with a metal chain to the bed. Resident #4 stated that [Resident #4] was in the facility due to heart and vascular problems. Resident #4 stated that the food was good and that they were not allowed to leave the room, only for a shower. The resident stated that they were not allowed to intermingle with other residents and were only able to talk on the phone privately with his/her attorney. Resident #4 stated that otherwise there was no privacy when speaking on the phone. Resident #4 also stated that [he/she] was not allowed to attend community dining or community activities.</p> <p>On 07/11/2024 at 11:12 AM, Surveyor #1 and Surveyor #2 were given permission from the detention guard to interview Resident #1, who was cognitively intact . The resident stated that they were admitted to the facility with the diagnoses of osteomyelitis and colitis and needed intravenous antibiotic therapy. The resident indicated that they did not have any open wounds. 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 that they had not left the room except for showering. The resident stated that this was the only time that they could leave the room .</p> <p>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 6th floor and had the diagnoses of Methicillin Resistant Staphylococci Aureus (MRSA) in the right axilla (armpit) and was on oral antibiotics. She also identified the resident as a prisoner. She stated that Resident #3 was not allowed to come out of the room unless it was to shower and had to eat meals in the room. She stated that the resident had activities in the room but was not allowed to attend activities in the main activity room because there was no intermingling with prisoners and LTC residents. LPN/UM #1 stated that Resident #7 also resided on the 6th floor and had a history of back pain. She stated that Resident #7's restrictions were the same for Resident #3.</p> <p>On 07/11/2024 at 11:35 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Recreation (DOR) who stated that she was informed by the Licensed Nursing Home Administrator (LNHA) that when the JIRs were 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 any activities out of their rooms. She stated that she provided the JIR residents with a basket of puzzles and cards on admission.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 07/11/2024 at 11:42 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Social Work (DSW) who stated that she had been employed by the facility for about 1 (one) year. She 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. She explained the process of completing an advanced directive, discharge planning and held care plan meetings. She stated that when the JIR 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 in the room guarded and not being able to freely leave the room was a form of resident seclusion. She stated that the JIR residents were being isolated for safety reasons and that was against the federal regulations.</p> <p>On 07/12/2024 at 9:15 am, Surveyor #3, Surveyor #4, and Surveyor #5 toured the third floor and observed armed guards standing in the hallway near Resident #1, Resident #4, and Resident #10's room. Further observation revealed that there were armed guards standing inside the rooms. Surveyor # 4 observed Residents #4 and #10 from the hallway and were observed to be covered with blankets and the guards prevented the surveyor from entering the rooms and from interviewing the residents.</p> <p>On 07/12/2024 at 9:18 am, Surveyor #4 interviewed Licensed Practical Nurse #2 (LPN #2), who stated she could give the residents medication and the guards would identify the justice involved residents (JIR), and the guards would watch her give the medication to the residents. LPN #2 further stated that there were always two guards present, and one guard would observe the nursing care and staff were not allowed to pull the curtain to provide privacy. She further stated that she and all the staff were supervised by the Feds.</p> <p>On 07/12/2024 at 9:30 AM, Surveyor #4 interviewed an unsampled resident who stated that they are aware there are prisoners at the facility and the prisoners do not come out of their rooms and do not participate in activities with other residents.</p> <p>On 07/12/2024 at 09:34 AM, Surveyor #1 and Surveyor #2 interviewed the LNHA who stated that the facility could accommodate the JIRs medical needs, however after he received the Centers for Medicare and Medicaid Services (CMS) memo S &amp; C: 16-21-ALL, with a revised date 12/23/2016, he understood that it was against federal regulation to restrain or seclude the JIRs. He stated that he called the nursing home in New York to inform them to stop sending the JIRs 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 JIR residents had nowhere else to go. He then stated that it was not the facility that was imposing the restrictions on the JIRs, it was the Bureau of Prisons that was imposing them. He added that the facility was aware that the JIRs were being treated differently by the facility than the regular facility residents and that it was not the facilities standard of practice, however he felt that the Department of Justice (DOJ) was a strong governing body and that he was between the Department of Health and the DOJ.</p> <p>On 07/12/2024 at 9:40 AM, Surveyor #3, Surveyor #4, and Surveyor #5 interviewed the 3rd-floor Unit Manager (UM), who stated that the JIR were served all their meals on disposable plates, utensils, and cups, and the prison guards check their meals before serving. The UM further stated that the JIR's shower schedule was Tuesday and Thursday in the evening, and the prison guard would stay in the shower room with the JIR.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>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 prison guard that interviews were not permitted but we could observe the JIR through the doorway of their rooms. 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 ankle restraint affixed by a chain to the resident's bed. Resident #9 was observed in bed with an ankle restraint affixed by a chain to the resident's bed.</p> <p>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 JIRs stayed in their rooms all day except on shower days. LPN#1 stated the JIRs do not participate in group activities, go into the main dining area, and does not believe they were allowed visitors.</p> <p>On 07/12/2024 at 12:15 PM, Surveyor #1 and Surveyor #2 interviewed the LNHA who stated that residents being secluded to their room, secluded from other residents, and not being able to attend activities or eat in the main dining rooms were all a form of seclusion, however it was not the LNHA that was enforcing that on the JIR residents, it was the Bureau of Prisoners.</p> <p>1. According to the Admission Record (AR), Resident #1 was admitted to the facility with diagnoses which included but was not limited to osteomyelitis (infection of the bone) of the right hand. According to the Admission progress note dated 07/02/2024 at 3:20 PM, the resident was alert and oriented.</p> <p>Review of the Admission Assessment (AA) dated 07/02/2024, Resident #1 was assessed as not having any behaviors and utilized no physical or chemical restraints, however Resident #1 was observed by Surveyor #1 (S1) and Surveyor #2 (S2) on 07/11/24 at 11:04 AM, wearing metal ankle cuffs.</p> <p>Review of the physician's orders (PO) reflected that there were no orders for the use of metal ankle cuffs, however a PO order dated 07/02/24, reflected an order to monitor skin integrity under the cuff area every shift. There was no consent signed for the use of the metal ankle cuffs.</p> <p>Review of the resident's Individualized Care Plans (CP) dated 07/02/24, revealed that a CP was not implemented for the use of restraints. The CP did not address that the resident required constant supervision from the detention guards for all aspects of activities of daily living (ADLs). The CP did not address that the resident was not permitted to leave the room unless for showering and accompanied by the detention guards and there was no documentation on the CP to address restrictions from attending community activities and community dining.</p> <p>2. According to the AR, Resident #2 was admitted to the facility with the diagnoses which included but was not limited to multiple sclerosis (autoimmune disease). A comprehensive MDS was in progress and unavailable for review. Resident #1 did not sign the facility AA.</p> <p>Review of the AA dated 07/05/2024, Resident #2 was assessed as not having any behaviors and utilized no physical or chemical restraints, however Resident #2 was observed by Surveyor #1 and Surveyor #2 on 07/11/24 at 10:44 AM, wearing metal ankle cuffs.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Sinai Post Acute Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  65 Jay Street Newark, NJ 07103	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the physician's orders (PO) reflected that there were no orders for the use of metal ankle cuffs, however the Treatment Administration Record (TAR) reflected an order dated 07/11/24, to check skin integrity under on bilateral ankle cuffs every shift. There was no consent signed for the use of the metal ankle cuffs.</p> <p>Review of the resident's CP dated 07/05/24, revealed that a CP was not implemented for the use of restraints. The CP did not address that the resident required constant supervision from the detention guards for all aspects of activities of daily living (ADLs). The CP did not address that the resident was not permitted to leave the room unless for showering and accompanied by the detention guards and there was no documentation on the CP to address restrictions from attending community activities and community dining.</p> <p>3. According to the AR, Resident #3 was admitted to the facility on [DATE] with diagnoses which included but not limited to polyneuropathy.</p> <p>Review of the AA dated 07/05/24, revealed that Resident # 3 was assessed as not having any behaviors or requiring physical or chemical restraints.</p> <p>Review of a Progress Note (PN) dated 07/05/24, revealed Resident # 3 was alert and verbally responsive.</p> <p>Review of the CP initiated on 07/05/24, revealed no CPs were initiated regarding supervision with ADLs, restraints, activities, or seclusion.</p> <p>4. According to the AR, Resident #4 was admitted into the facility July 2, 2024, with diagnoses which included but not limited; to Polyneuropathy (simultaneous malfunction of many peripheral nerves throughout the body causes pain, tingling or burning sensations on the body), hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone), hypertension (elevated blood pressure), Atrial Fibrillation (irregular, rapid heart rate) and dysphagia (difficulty swallowing).</p> <p>Review of the Order Summary Report revealed a physician order (PO) dated 7/11/24, to check the skin integrity on bilateral ankle cuffs every shift. Further review revealed that there were no orders for restraints and seclusion from the rest of the facility with continuous monitoring from law enforcement.</p> <p>Review of the AA dated 07/02/2024, the resident was assessed as not having any behavior problems, was independent with their decision-making, and not requiring physical or chemical restraints.</p> <p>Review of the resident's CP dated 07/02/24, did not include focus areas that would address supervision from law enforcement with Activities of daily living, restraints, activities, or seclusion.</p> <p>Review of the admission summary progress note dated 07/02/24 at 01:37 PM, revealed the resident was alert and oriented.</p> <p>5. According to the AR, Resident #5 revealed was admitted to the facility on [DATE], with diagnoses which included but not limited to local infection of the skin and subcutaneous tissue.</p> <p>Review of the PN dated 07/10/24, revealed that Resident # 5 was alert and verbally responsive.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the AA dated 07/03/24, the resident was assessed as not having any behaviors or requiring physical or chemical restraints.</p> <p>Review of the CP initiated on 07/03/24, revealed no CPs were initiated regarding supervision with ADLs, restraints, activities, or seclusion.</p> <p>6. According to the AR, Resident # 6 was admitted to the facility on [DATE].</p> <p>Review of Resident # 6's AR revealed the resident was admitted to the facility with diagnoses which included but not limited to; polyneuropathy.</p> <p>Review of the AA dated 07/03/24, the resident was not assessed as having any behaviors or requiring physical or chemical restraints.</p> <p>Review of the CP initiated on 07/03/24, revealed no CPs were initiated regarding supervision with ADLs, restraints, activities, or seclusion.</p> <p>7. According to the AR, Resident #7 was admitted to the facility on [DATE], with diagnoses which included but not limited to; low back pain.</p> <p>Review of a PN dated 07/04/24, revealed that Resident # 7 was alert and oriented.</p> <p>The AA dated 07/04/24, indicated that resident was assessed as not having any behaviors or requiring physical or chemical restraints.</p> <p>Review of the CP initiated 07/04/24, revealed no CPs were initiated regarding supervision with ADLs, restraints, activities, or seclusion.</p> <p>8. According to the AR, Resident #8 was admitted [DATE], to the facility with diagnoses which included but not limited to dilated cardiomyopathy (disease of the heart muscle).</p> <p>Review of the AA dated 07/08/24, revealed that the resident was assessed as not having any behaviors or requiring physical or chemical restraints.</p> <p>Review of a PN dated 07/09/24, revealed that Resident # 8 was alert and verbally responsive.</p> <p>Review of the Care Plan initiated on 07/08/24, revealed no CPs were initiated regarding supervision with ADLs, restraints, activities, or seclusion.</p> <p>9. According to the AR, Resident #9 was admitted to the facility with diagnoses which included but was not limited to dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement).</p> <p>Review of a PN dated 07/10/2024 at 1:36 PM, revealed that the resident was alert with periods of forgetfulness.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the AA dated 7/5/2024, included that the resident was assessed as not having any behaviors or requiring physical or chemical restraints, however on 07/11/24 at 10:43 AM, Surveyor #1 and Surveyor #2 observed the resident in the room with metal cuff affixed to both ankles.</p> <p>Review of the physician's orders (PO) reflected that there were no orders for the use of metal ankle cuffs, however the PO reflected an order dated 07/11/24, to check skin integrity under on bilateral ankle cuffs every shift.</p> <p>There were no consents found in the medical record regarding the use of ankle restraints.</p> <p>Review of the CP dated 07/05/24, revealed that a CP was not implemented for the use of restraints. The CP did not address that the resident required constant supervision from law enforcement officers for all aspects of activities of daily living (ADLs). The CP did not address that the resident was not permitted to leave the room unless for showering and accompanied by law enforcement officers and there was no documentation on the CP to address restrictions from attending community activities and community dining.</p> <p>10. According to the AR, Resident #10 had diagnoses which included but not limited to; enterocolitis due to clostridium Difficile (inflammation of the digestive tract due to an infection), depression, anxiety disorder, and diverticulitis (inflammation or infection in digestive tract).</p> <p>Review of the PO dated 07/02/24, revealed no order for restraints or seclusion from the rest of the facility with continuous monitoring from law enforcement.</p> <p>Review of the resident's CP dated 07/02/24, did not include focus areas that would address supervision of law enforcement with Activities of daily living, restraints, activities, or seclusion.</p> <p>Review of the PN dated 07/02/24 at 2:40 PM, revealed the resident was alert and oriented x 3 and was able to make their own decisions.</p> <p>11. According the the AR, Resident #11 was admitted to the facility with diagnoses which but was not limited to; polyneuropathy (Damage to multiple peripheral nerves).</p> <p>Review of a progress note (PN) dated 07/08/24 at 4:08 PM, revealed that the resident was alert verbally responsive and able to make their needs known.</p> <p>Review the AA dated 07/03/24, the resident was assessed as not having any behaviors or requiring physical or chemical restraints, however Resident #11 was observed by Surveyor #1 and Surveyor #2 on 07/11/24 at 10:44 AM, wearing metal ankle cuffs.</p> <p>Review of the PO reflected that there were no orders for the use of metal ankle cuffs, however Treatment Administration Record (TAR) reflected an order dated 07/11/24, to check skin integrity under on bilateral ankle cuffs every shift.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the CP dated 07/03/24, revealed that a CP was not implemented for the use of restraints. The CP did not address that the resident required constant supervision from the detention guards for all aspects of ADLs. The CP did not address that the resident was not permitted to leave the room unless for showering and accompanied by law enforcement officers and there was no documentation on the CP to address restrictions from attending community activities and community dining.</p> <p>The comprehensive Minimum Data Set (MDS), an assessment tool that facilitates a resident's care, was in progress for Residents #1 through #11, and unable to be reviewed.</p> <p>The facility Admission Agreement (a contract which included all documents that a resident or responsible person must sign at the time of, or as a condition of, admission) was not signed by Residents #1 through #11.</p> <p>8:39-4.1 (a)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>36419</p> <p>COMPLAINT # NJ 175415</p> <p>Based on observation, interview, review of resident medical records and other pertinent facility documentation it was determined the facility failed to ensure that 11 of 11 residents involved in the Justice System [Justice Involved Residents] (JIRs) (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11) were free from physical restraints. The failure to treat residents respectfully and in a dignified manner had the likelihood to cause serious injury, psychological harm and mental anguish. These residents were restrained with ankle shackles that were attached to the beds with metal chains. This was cited as a pattern that immediately jeopardizes the health and safety of the JIRs, as well as all other residents that reside in the facility which resulted in an Immediate Jeopardy (IJ) situation.</p> <p>The IJ began on 07/02/24, the date that the first JIR (Resident #1) was admitted to the facility and was restrained with metal shackles by law enforcement officers of the Bureau of Prison [BOP]. The IJ situation was identified on 7/12/24 when Residents #1, 2, 3, 4, 5, 6, 7, 8, 9,10, and 11 were observed being restrained with ankle shackles attached to their beds with metal chains guarded by law enforcement officers.</p> <p>The facility's Licensed Nursing Home Administrator (LNHA) was informed of the IJ situation on 07/12/24 at 3:49 PM, that an immediate jeopardy situation existed which also constituted Substandard Quality of Care (SQC) for 42 CFR 483.10 (e) (1) Free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>An acceptable removal plan was received on 7/29/24 at 9:59 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: All Justice Involved Residents were discharged from the facility as of 7/26/24. The facility will no longer admit Justice Involved Residents.</p> <p>The survey team verified the removal plan on-site on 7/29/24, and determined the was removed as of 7/26/24.</p> <p>The findings as are follows:</p> <p>Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016, S &amp; C 16-21-ALL, documented 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.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The facility policy dated 02/2024 and titled, Resident Rights indicated that all residents would be treated equally regardless of age, race, sex, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The resident has a right to be treated with dignity and respect including being free from any physical or chemical restraints imposed for the purposes of discipline or convenience. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility . the right to receive visitors of his or her own choosing subject to the resident's right to deny visitation when applicable .right to participate in family groups .the right for personal privacy includes accommodations, medical treatment, telephone communications, personal care, visits and meetings of family and residents groups.</p> <p>The facility policy dated 12/2010, revised 4/2024 and titled, Physical Restraints indicated that restraints should only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline of staff convenience. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms. Restraints should only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. The order shall include the specific reason for the restraint; how the restraint will be used to benefit the resident's medical symptom; and the type of restraint, and period of time for the use of the restraint.</p> <p>1. According to the Admission Record (AR), Resident # 1 was admitted to the facility with diagnoses which included osteomyelitis (infection of the bone) of the right hand . Review of the Admission Assessment (AA) dated 07/02/24, revealed Resident #1 was assessed as not having any behaviors, or requiring physical or chemical restraints. According to the admission progress note dated 07/02/24 at 3:20 PM, the resident was alert and oriented. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #1 did not sign the facility Admission Agreement (AA) or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>2. According to the AR, Resident #2 was admitted to the facility with diagnoses which included multiple sclerosis (autoimmune disease). Review of the AA dated 07/05/24, revealed Resident #2 was assessed as not having any behaviors, or requiring physical or chemical restraints. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #2 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>3. According to the AR, Resident #3 was admitted to the facility with diagnoses which included polyneuropathy (peripheral nerve damage). Review of the AA dated 07/05/24, revealed Resident #3 was assessed as not having any behaviors, or requiring physical or chemical restraints. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #3 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>4. According to the AR, Resident #4 was admitted to the facility with diagnoses which included polyneuropathy. Review of the AA dated 07/02/24, revealed Resident #4 was assessed as not having any behaviors, or requiring physical or chemical restraints. The AA indicated the resident was independent in their decision-making. According to the admission summary progress note dated 07/02/24 at 1:37 PM, the resident was alert and oriented. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #4 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>5. According to the AR, Resident #5 was admitted to the facility with diagnoses which included local infection of the skin and subcutaneous tissue. Review of the AA dated 07/03/24, revealed Resident #5 was assessed as not having any behaviors, or requiring physical or chemical restraints. According to an Interdisciplinary progress note dated 07/10/24, the resident was alert and verbally responsive. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #5 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>6. According to the AR, Resident #6 was admitted to the facility with diagnoses which included polyneuropathy. Review of the AA dated 07/03/24, revealed Resident #6 was assessed as not having any behaviors, or requiring physical or chemical restraints. According to the Social Service progress note dated 07/03/24 at 9:45 PM, resident #6 was assessed as alert and oriented with a Basic Interview for Mental Status (BIMS) of 15 out of 15 which indicated that the resident's cognition was intact. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #6 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>7. According to the Admission Record Resident #7 was admitted to the facility with diagnoses which included low back pain. Review of the AA dated 07/04/24, revealed Resident #7 was assessed as not having any behaviors, or requiring physical or chemical restraints. According to the admission summary note dated 07/04/24 at 11:12 AM, the resident was alert, and able to verbalize his/her needs to staff. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #7 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>8. According to the AR, Resident #8 was admitted to the facility with diagnoses which included dilated cardiomyopathy (disease of the heart muscle). Review of the AA dated 07/08/24, revealed Resident #8 was assessed as not having any behaviors, or requiring physical or chemical restraints. According to the Admission progress note dated 07/09/24 at 2:40 PM, the resident was alert, responsive and able to make his/her needs known. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical. Further review of the medical record revealed that Resident #8 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>9. According to the AR, Resident #9 was admitted to the facility with diagnoses which included dementia. Review of the AA dated 7/5/24, revealed Resident #9 was assessed as not having any behaviors, or requiring physical or chemical restraints. According to the progress admission note dated 07/10/24 at 1:36 PM, the resident was alert with periods of forgetfulness. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #9 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>10. According to the AR, Resident #10 was admitted to the facility with diagnoses which included clostridium difficile colitis (C.diff) (bacterial infection of the colon). Review of the AA dated 07/02/24, revealed Resident #10 was assessed as not having any behaviors, or requiring physical or chemical restraints. The admission summary progress note dated 07/02/24 at 2:40 PM, resident was alert and oriented x3 and able to make their own decisions. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #1 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>11. According to the Admission Record Resident #11 was admitted to the facility with diagnoses which included polyneuropathy. Review of the AA dated 07/03/24, revealed Resident #11 was assessed as not having any behaviors, or requiring physical or chemical restraints. According to the progress note dated 07/08/24 at 4:08 PM, the resident was alert verbally responsive and able to make their needs known. A review of the Individualized Care Plans (CP) revealed no CPs were implemented for the use of physical restraints. Further review of the medical record revealed that Resident #11 did not sign the facility AA or consent for the use of physical restraints. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</p> <p>On 07/11/24 at 09:00 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Nursing (DON) who stated that she was notified by the facilities Corporate Offices (CO) that JIRs were entering the facility. She stated that the facility's CO instructed the facility's administration (DON, Administrator, Admission Coordinator, Social Services, Activities Director, and Unit Managers) not to mix the JIR with other residents and that they needed to be roomed together. She stated that the JIRs would be guarded by law enforcement and their ankles would be shackled with metal cuffs. She stated that the CO also instructed the facility not to mix or intermingle the JIR with other residents in the facility.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 07/11/24 at 09:35 AM, Surveyor #1 and #2 interviewed the Minimum Data Set Coordinator (MDSC) who stated that the eleven (11) JIRs had entry MDSs completed, however comprehensive MDSs were not completed until day 14 of admission. The MDSC provided the surveyors with the entry MDSs for all 11 JIRs.</p> <p>On 07/11/24 at 10:20 AM, Surveyor #1 and Surveyor #2 toured the fourth floor and interviewed Licensed Practical Nurse (LPN#1) who stated that he worked for an agency and that it was his first time working at the facility. LPN #1 stated that there were 6 (six) JIRs.</p> <p>On 07/11/24 at 10:25 AM, Surveyor #1 observed the JIRs from the hallway. The six residents that resided on the fourth floor were observed in their rooms being guarded by law enforcement officers.</p> <p>On 07/11/24 at 10:30 AM, Surveyor #1 and Surveyor #2 interviewed a gentleman outside in the hallway who identified himself as a contracted Supervisor of the United States Marshalls (SUSM). He stated that the surveyors were not allowed to enter the JIRs rooms and would not allow the surveyors to interview the JIR on the 4 (four) [NAME] (Resident #2, 5, 6, 8, 9, and 11). The SUSM explained to Surveyor #1 and Surveyor #2 that the JIRs were at the facility for rehabilitation services. He stated that all JIRs were to wear metal ankle restraints, and all were to be chained to the bed. He explained that wearing of ankle restraints depended on the resident's medical condition. He stated that the JIRs could not attend facility activities and could not intermingle with other residents and could only talk amongst other JIR residents. He stated that the JIR residents could only leave their rooms with escorts for showering or any other reason which was approved by the U.S Marshall. He stated that the JIRs must eat in their rooms and could not eat in the main dining room with the other residents. He stated that visitation of anyone must be approved US Attorney or Judge.</p> <p>On 07/11/24 at 10:42 AM, Surveyor #1 observed Resident #5 and #6 from the hallway lying in bed wearing metal ankle restraints that were chained to the bed and guarded by 3 detention officers.</p> <p>On 07/11/24 at 10:43 AM, Surveyor #1 observed from the hallway Resident #8 and #9 in their room chained with metal ankle restraints and guarded by 3 detention officers.</p> <p>At 07/11/24 at 11:00 AM, Surveyor #1 and Surveyor #2 toured the 3rd floor Unit. The surveyors interviewed LPN #2 who stated that there were 3 JIRs on the unit (Resident #1, #4 and #10).</p> <p>On 07/11/24 at 11:05 AM, Surveyor #1 and Surveyor #2 were given permission from the detention guard to interview Resident #4 who was observed in bed with glasses and was pleasant and cooperative. The surveyor observed that the Resident #4 was wearing plastic ankle restraints. The guard in the room indicated that the resident had medical issues and was required to wear the plastic restraints (ankle cuffs) instead of metal. The surveyors observed the plastic ankle cuffs were shackled with a metal chain to the bed. Resident #4 stated that they were in the facility due to heart and vascular problems. Resident #4 stated that the food was good and that they were not allowed to leave the room, only for a shower. The resident stated that they were not allowed to intermingle with other residents and were only able to talk on the phone privately with their attorney. Resident #4 stated that otherwise there was no privacy when speaking on the phone.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315236	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2024
NAME OF PROVIDER OR SUPPLIER  Sinai Post Acute Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  65 Jay Street Newark, NJ 07103	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>On 07/11/24 at 11:12 AM, Surveyor #1 and Surveyor #2 were given permission from the detention guard to interview Resident # 1 who was cognitively intact. The resident stated that they were admitted to the facility with the diagnoses of osteomyelitis and colitis and needed intravenous antibiotic therapy. 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 that they had not left the room except for showering. The resident stated that that was the only time that they could leave the room.</p> <p>On 07/11/24 at 11:20 AM, Surveyor #1 and Surveyor #2 interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #1) who stated that Resident #3 resided on the 6th floor and had the diagnoses of Methicillin Resistant Staphylococci Aureus (MRSA) in the right axilla (armpit) and was on oral antibiotics. She also identified the resident as a prisoner. She stated that Resident #3 was not allowed to come out of the room unless for a shower and had to eat meals in the room. She stated that the resident had activities in the room but was not allowed to attend activities in the main activity room because there was no intermingling of prisoners with LTC residents. LPN/UM #1 stated that Resident #7 also resided on the 6th floor and had a history of back pain. She stated that Resident #7's restrictions were the same and Resident #3.</p> <p>On 07/11/24 at 11:35 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Recreation (DOR) who stated that she was informed by the Licensed Nursing Home Administrator (LNHA) that when the JIR were admitted to the facility that she was to have no interaction with them. She stated that she was told not to complete an activities assessment on admission. She stated that she provided the JIR residents with a basket of puzzles and cards on admission, however the residents were not to attend any activities out of their rooms.</p> <p>On 07/11/24 at 11:42 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Social Work (DSW) who stated that she had been employed by the facility for about 1 (one) year. She 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. She explained the process of completing an advanced directive, discharge planning and held Care Plan meetings. She stated that when the JIR 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 in the room guarded and not being able to freely leave the room was a form a resident seclusion. She stated that the JIR residents were being isolated for safety reasons and that that was against the federal regulations.</p> <p>On 07/12/24 at 09:34 AM, Surveyor #1 and Surveyor #2 interviewed the LNHA who stated that the facility could accommodate the JIRs medical needs, however after he received the Centers for Medicare and Medicaid Services (CMS) memo S &amp; C: 16-21-ALL, with revised date 12/23/2016, he understood that it was against federal regulation to restrain or seclude the JIRs. He stated that he called the nursing home in New York to inform them to stop sending the JIRs 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 JIRs had nowhere else to go. He then stated that it was not the facility that was imposing the restrictions on the JIRs, it's the Bureau of Prisons that was imposing them. He added that the facility was aware that the JIRs were being treated differently by the facility than other residents and that it was not the facility's standard of practice however he felt that the Department of Justice (DOJ) was a strong governing body and that he was between the Department of Health and the DOJ.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>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 prison guard interviews were not permitted but could be observed through the doorway of their rooms. The surveyors observed Resident #8 in their room in a wheelchair with an ankle restraint connected by a metal chain to the resident's bed. Resident #9 was observed in bed with an ankle restraint connected by a chain to the resident's bed.</p> <p>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 JIRs stay shackled in their rooms all day except on shower days.</p> <p>On 07/12/24 at 12:15 PM, Surveyor #1 and Surveyor #2 interviewed the LNHA who stated that resident being secluded to their room, seclusion from other residents and not being able to attend activities or eat in the main dining rooms were all a form of seclusion, however it was not the LNHA that was enforcing this on the JIR residents, it was the Bureau of Prisoners.</p> <p>On 07/12/24 at 1:24 PM, Surveyors conducted a phone interview with the Medical Director (MD) who stated that he had been on vacation when the 11 JIRs were admitted to the facility. He was not aware that the 11 JIRs were secluded to their rooms or that they were all restrained with ankle shackles. The MD further stated that he did not write physician orders for restraints for any of the 11 JIRs.</p> <p>On 07/15/24 at 08:45 AM, Surveyors #2 and #3 together toured the 3rd floor 300 unit and observed Residents #4 and #10 in their rooms with ankle shackles attached to their beds with metal chains.</p> <p>On 07/15/24 at 08:51 AM, Surveyors #2 and #3 toured the 4th floor 400 unit and observed Resident #11 in hallway of the 400 unit in a wheelchair escorted by 3 prison guards with hand cuffs and ankle shackles in place. At 08:54 AM, the surveyors observed Residents #6, #5 and #8 in their rooms with ankle shackles attached to their beds with metal chains.</p> <p>On 07/15/24 at 09:44 AM, Surveyor #2, #3 and #5 together interviewed the LNHA who stated that until he met with or was contacted by the New Jersey Department of Health (NJDOH), Centers for Medicare and Medicaid (CMS), and [contracted complany] he could not submit a removal plan for any of the Immediate Jeopardize because the JIRs would have to be removed from the facility and that was not possible at this time.</p> <p>8:39-4.1 (6)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44605</p> <p>Complaint # NJ 175415</p> <p>Based on observation, interview, review of medical records and other pertinent facility documentation, it was determined that the facility failed to provide a meaningful group and individualized activity programs that reflected the resident's preferences.</p> <p>This deficient practice was identified for 11 of 11 Justice Involved Residents (JIRs) (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11), reviewed for activities, and was evidenced by the following:</p> <p>Reference: The Centers for Medicare and Medicaid Services (CMS) updated Guideline to Surveyors on Federal Requirements for Providing services to Justice Involved individuals, revised 12/23/2016, S &amp; C 16-21-ALL, documented 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.</p> <ol style="list-style-type: none"> <li>1. According to the Admission Record, Resident # 1 was admitted to the facility on [DATE], with diagnoses which included osteomyelitis (infection of the bone) of the right hand. According to the admission progress note dated 07/02/24 at 3:20 PM, the resident was alert and oriented. A review of the Individualized Care Plans (CP) revealed no CP were implemented for activities, or seclusion. The comprehensive Minimum Data Set (MDS) was in progress and not yet completed.</li> <li>2. According to the Admission Record Resident #2 was admitted to the facility on [DATE], with diagnoses which included multiple sclerosis (autoimmune disease). A review of the CP revealed no CPs were implemented for restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</li> <li>3. According to the Admission Record Resident #3 was admitted to the facility on [DATE], with diagnoses which included polyneuropathy (peripheral nerve damage). A review of the CP revealed no CPs were implemented for restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</li> <li>4. According to the Admission Record Resident #4 was admitted to the facility on [DATE], with diagnoses which included polyneuropathy. The admission assessment indicated the resident was independent in his/her decision-making. According to the admission summary progress note dated 07/02/24 at 1:37 PM, the resident was alert and oriented. A review of the CP revealed no CPs were implemented for restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</li> <li>5. According to the Admission Record, Resident #5 was admitted to the facility on [DATE], with diagnoses which included local infection of the skin and subcutaneous tissue. According to an Interdisciplinary progress note dated 07/10/24 the resident was alert and verbally responsive. A review of the CP revealed no CPs were implemented for the supervision of ADL care, use of restraints, restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. According to the Admission Record Resident #6 was admitted to the facility on [DATE], with diagnoses which included polyneuropathy. According to the Social Service progress note dated 07/03/24 at 9:45 PM, resident #6 was assessed as alert and oriented with a Basic Interview for Mental Status of 15 out of 15. A review of the CP revealed no CPs were implemented for restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</p> <p>7. According to the Admission Record Resident #7 was admitted to the facility on [DATE], with diagnoses which included low back pain. According to the Admission summary note dated 07/04/24 at 11:12 AM, the resident was alert, and able to verbalize his/her needs to staff. A review of the CP revealed no CPs were implemented restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</p> <p>8. According to the Admission Record Resident #8 was admitted to the facility on [DATE], with diagnoses which included dilated cardiomyopathy (disease of the heart muscle). According to the Admission progress note dated 07/09/24 at 2:40 PM, the resident was alert, responsive and able to make his/her needs known. A review of the CP revealed no CPs were implemented for restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</p> <p>9. According to the Admission Record Resident #9 was admitted to the facility on [DATE], with diagnoses which included dementia. According to the progress admission note dated 07/10/24 at 1:36 PM, the resident was alert with periods of forgetfulness. A review of the CP revealed no CPs were implemented restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</p> <p>10. According to the Admission Record Resident #10 was admitted to the facility on [DATE], with diagnoses which included clostridium difficile colitis (C.diff) (bacterial infection of the colon). The admission summary progress note dated 07/02/24 at 2:40 PM, resident was alert and oriented x3 and able to make his/her own decisions. A review of the CP revealed no CPs were implemented for restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</p> <p>11. According to the Admission Record Resident #11 was admitted to the facility on [DATE], with diagnoses which included polyneuropathy. According to the progress note dated 07/08/24 at 4:08 PM, the resident was alert verbally responsive and able to make their needs known. A review of the CP revealed no CPs were implemented for restriction with attending activities, and seclusion to room except for showers. The comprehensive MDS was in progress and not yet completed.</p> <p>On 07/11/24 at 10:30 AM, JIR interviews were attempted by Surveyor #1 and #2, and was prohibited by the law enforcement officers. A U.S. Marshall was interviewed on 07/11/24, and stated that all JIRs required approval by the U.S Attorney's office or judge to have interviews or visitation.</p> <p>On 07/11/24 at 11:05 AM, Surveyor #2 was allowed by the prison guard to interview Resident #4 who stated they were secluded to room and not allowed to intermingle with other residents.</p> <p>On 07/11/24 at 11:12 AM, Surveyors #1 and #2 interviewed Resident #1, who stated that they were only allowed to leave the room for showers.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 07/11/24 at 11:35 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Recreation (DOR) who stated that she was informed by the Licensed Nursing Home Administrator (LNHA) that when the JIR were admitted to the facility that she was to have no interaction with them. She stated that she was told not to complete an activities assessment on admission. She stated that she provided the JIR residents with a basket of puzzles and cards on admission, however the residents were not to attend any activities out of their rooms.</p> <p>On 07/12/24 at 9:30 AM, Surveyors #3, #4, and #5 interviewed the 3rd floor Unit Manager (UM), who stated the JIR remain in their rooms at all times and did participate in group activities.</p> <p>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 prison guard interviews were not permitted but could observed the JIR through the doorway of their rooms.</p> <p>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 the JIRs stay in their rooms all day except on shower days. LPN #1 stated the JIRs did not participate in group activities.</p> <p>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 7/8/24 for, recreation as tolerated. Resident #9 had a PO with a start date of 8/5/24 for, recreation as tolerated. No recreation screen, notes or care plans were noted for either resident.</p> <p>On 07/15/24 at 10:00 AM, the LNHA provided the surveyors with a facility policy titled, Activity Programs. The activity programs policy with a revised date of February 2024 states 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.</p> <p>NJAC 8:39-7.3(a)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 43936</p> <p>Complaint # NJ 175415</p> <p>Refer to F 550 K, Refer to F 557 K, Refer to F 561 K, Refer to F 603 K, Refer to F 604 K, Refer F to 679 E.</p> <p>Based on interviews, record review, and review of facility documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to a.) ensure the facility implemented policies and procedures for Resident Rights and Self Determination as well as policies and procedures to prevent physical restraints and seclusion. The LNHA also failed to ensure 11 of 11 Justice Involved Residents (JIRs) (Resident #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11) b.) signed Admission Agreements on admission to the facility and c.) were afforded the autonomy to participate in group activities, community dining, serving meals in a dignified manner, freely communicate with visitors, and to leave rooms at will . The failure to ensure the facility established and maintained systems that were effective and efficient to operate the facility in a manner to safely meet residents' needs had the likelihood to cause serious injury and psychological harm which resulted in an IJ situation.</p> <p>The Immediate Jeopardy (IJ) began on 07/02/24, the date that the first JIR (Resident #1) was admitted to the facility and was secluded by law enforcement officers of the Bureau of Prison (BOP). The IJ situation was identified on 07/12/24, when Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11 were observed being secluded to their rooms guarded by law enforcement officers, secluded from participating in group activities, community dining, being served meals in a dignified manner, intermingling with other residents, communicating with visitors and leaving the room at will.</p> <p>The facilities Licensed Nursing Home Administrator (LNHA) was informed of the IJ situation on 07/12/24 at 3:49 PM, that an Immediate Jeopardy situation existed.</p> <p>An acceptable removal plan was received on 7/29/24 at 9:59 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: All Justice Involved Residents were discharged from the facility as of 7/26/24. The facility will no longer admit Justice Involved Residents. Administration will be able to follow policies pertaining to resident rights, restraints, ADL's and activities.</p> <p>The survey team verified the removal plan on-site on 7/29/24, and determined the was removed as of 7/26/24.</p> <p>The findings were as follows:</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>The facility policy dated 02/2024 and titled, Resident Rights indicated that all residents would be treated equally regardless of age, race, sex, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, or gender identity or expression. The resident has a right to be treated with dignity and respect including being free from any physical or chemical restraints imposed for the purposes of discipline or convenience. The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility . the right to receive visitors of his or her own choosing subject to the resident's right to deny visitation when applicable .right to participate in family groups .the right for personal privacy includes accommodations, medical treatment, telephone communications, personal care, visits and meetings of family and residents groups.</p> <p>A review of a facility policy titled Resident Rights dated 02/2024, included under Policy Explanation and Compliance Guidelines that prior to or upon admission, the social service designee, or another designated staff member, will inform the resident of the resident's rights and responsibilities. 2. Exercise of rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. 5. Respect and Dignity. The resident has a right to be treated with respect and dignity including the right to be free of any physical or chemical restraint . 6. Self-determination. The resident has the right to, and the facility must promote and facilitate residents' self-determination through support of resident's choice, including but not limited to the right to choose activities, make choices about aspect of his or her life, right to interact with members of the community both inside and outside the facility, and the right to receive visitors. 7. Information and communication. The resident has the right to be informed of his or her rights and of all the rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. 8. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. Personal privacy includes accommodations, medical treatment written and telephone communication, personal care, visits, and meetings of family and resident groups.</p> <p>The facility policy dated 12/2010, revised 4/2024 and titled, Physical Restraints indicated that restraints should only be used for the safety and well-being of the residents and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptoms and never for discipline of staff convenience. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions that may improve the symptoms. Restraints should only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. The order shall include the specific reason for the restraint; how the restraint will be used to benefit the resident's medical symptom; and the type of restraint, and period of time for the use of the restraint.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 07/15/24 at 10:00 AM, the LNHA provided the surveyors with a facility policy titled, Activity Programs. The activity programs policy with a revised date of February 2024 states 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.</p> <p>The LNHA 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 states 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 states 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.</p> <p>A review of the facility policy titled Care Plan with a review date of April 2024 revealed under, Policy that, It is the policy of [NAME] that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner.</p> <p>A review of the undated facility's Job Description and Performance Standards for Administrator document revealed that the duties of the Administrator included but not limited to:</p> <p>a.) Develop, maintain, and implement operational policies and procedures to meet residents' needs in compliance with federal, state, and local requirements.</p> <p>b.) Determine the personnel requirements of the facility and hire or arrange for sufficient staff to implement the facility policies and procedures.</p> <p>c.) Develop a monitoring system to assure compliance with federal, state, and local requirements.</p> <p>On 07/11/24 at 09:00 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Nursing (DON) who stated that she was notified by the facilities Cooperate Offices (CO) that JIRs were entering the facility. She stated that the facilities CO instructed the facilities administration (DON, Administrator, Admission Coordinator, Social Services, Activities Director, and Unit Managers) not to mix the JIR with other residents and that they needed to be roomed together. She stated that the JIRs would be guarded by law enforcement and their ankles would be shackled with metal cuffs. She stated that the CO also instructed the facility not to mix or intermingle the JIR with other residents in the facility.</p> <p>On 07/11/2024 at 09:35 AM, Surveyor #1 and #2 interviewed the Minimum Data Set Coordinator (MDS) who stated that the eleven (11) JIRs had entry MDS's completed,</p> <p>however comprehensive MDS's were not completed until day 14 of admission. The MDS provided the surveyors with the entry MDS's for all 11 JIRs.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Sinai Post Acute Nursing and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  65 Jay Street Newark, NJ 07103	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 07/11/2024 at 10:20 AM, Surveyor #1 and Surveyor #2 toured the fourth floor and interviewed the Licensed Practical Nurse (LPN #1) who stated that he worked for an agency and that it was his first time working at the facility. LPN #1 stated that there were 6 (six) JIRs residing on his unit (Resident #2, 5, 6, 8, 9, and 11). He stated that there were law enforcement officers guarding the residents and that the residents wore metal ankle cuffs. He continued to explain that he was not sure what the residents' limitations were and was not aware of any behaviors that the JIRs had. He also added that he was not aware of any complaints about these residents from other residents that resided on his unit.</p> <p>On 07/11/2024 at 10:25 AM, Surveyor #1 observed the JIRs from the hallway. The six residents that resided on the fourth floor were observed in their rooms being guarded by law enforcement officers.</p> <p>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 Supervisor of the United States Marshals (SUMS). He stated that the surveyors were not allowed to enter the JIRs rooms and would not allow the surveyors to interview the JIR on the 4 (four) [NAME] unit (Resident #2, 5, 6, 8, 9, and 11). The SUMS explained to Surveyor #1 and Surveyor #2 that the JIRs were at the facility for rehabilitation services. He stated that all JIRs were to wear metal ankle restraints, and all were to be chained to the bed. 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 other JIR residents. He stated that the JIR residents could only leave their rooms with law enforcement escorts for showering or any other reason which was approved by the U.S. Marshals. He stated that the JIRs must eat in their rooms and could not eat in the main dining room with the other residents. He stated that visitation of anyone must be approved by the US Attorney or Judge.</p> <p>On 07/11/2024 at 10:42 AM, Surveyor #1 observed Resident #5 and #6 from the hallway lying in bed guarded by 3 (three) law enforcement officers. The residents were observed wearing metal ankle restraints that were chained to the bed.</p> <p>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 6th floor and had the diagnoses of Methicillin Resistant Staphylococci Aureus (MRSA) in the right axilla (armpit) and was on oral antibiotics. She also identified the resident as a prisoner. She stated that Resident #3 was not allowed to come out of the room unless it was to shower and had to eat meals in the room. She stated that the resident had activities in the room but was not allowed to attend activities in the main activity room because there was no intermingling with prisoners and long term care residents. LPN/UM #1 stated that Resident #7 also resided on the 6th floor and had a history of back pain. She stated that Resident #7's restrictions were the same as Resident #2.</p> <p>On 07/11/2024 at 11:35 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Recreation (DOR) who stated that she was informed by the Licensed Nursing Home Administrator (LNHA) that when the JIR were 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. She stated that she provided the JIR 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.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 07/11/24 at 11:42 AM, Surveyor #1 and Surveyor #2 interviewed the Director of Social Work (DSW) who stated that she had been employed by the facility for about one year. She 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. She stated that when the JIRs 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 in the room guarded and not being able to freely leave the room was a form a resident seclusion. She stated that the JIRs were being isolated for safety reasons and that was against the federal regulations.</p> <p>On 07/11/24 at 12:20 PM, during an interview with Surveyor # 1 the LNHA stated that shackles were considered a restraint. Further, he confirmed that seclusion, restriction of visitors, being served food with plastic and paper products and requiring supervision during activities of daily living were all violations of federal regulations of Long-Term Care regulations. He concluded that if a long-term care resident was not able to intermingle with other residents, then that would be a form of seclusion.</p> <p>On 07/12/2024 at 9:30 AM, during an interview with Surveyor # 3 and # 5, Unit Manager # 3 confirmed that the JIRs stay in their rooms. Further, she confirmed that the JIRs received disposable trays for their meals. Lastly, she confirmed that they only come out of their rooms for showers on Tuesday and Thursday evenings.</p> <p>On 07/12/24 at 09:34 AM, Surveyor #1 and Surveyor #2 interviewed the LNHA who stated that the facility could accommodate the JIRs medical needs however after he received the Centers for Medicare and Medicaid Services (CMS) memo S &amp; C: 16-21-ALL with revised date 12/23/2016, he understood that it was against federal regulation to restrain or seclude the JIRs. He stated that he called the nursing home in New York to inform them to stop sending the JIRs 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 JIRs had nowhere else to go. He then stated that it's not the facility that was imposing these restrictions on the JIRs, it's the Bureau of Prisons that is imposing them. He added that the facility was aware that the JIRs were being treated differently by the facility than other residents and that it was not the facility's standard of practice however he felt that the Department of Justice (DOJ) was a strong governing body and that he was between the Department of Health and the DOJ.</p> <p>On 07/12/24 at 12:15 PM, Surveyor #1 and Surveyor #2 interviewed the LNHA who stated that resident being secluded to their room, seclusion from other residents and not being able to attend activities or eat in the main dining rooms were all a form of seclusion, however it was not the LNHA that was enforcing this on the JIR residents, it was the Bureau of Prisoners.</p> <p>On 07/12/24 at 1:24 PM, Surveyors conducted a phone interview with the Medical Director (MD) who stated that he had been on vacation when the 11 JIRs were admitted to the facility. He was not aware that the 11 JIRs were secluded to their rooms or that they were all restrained with ankle shackles. The MD further stated that he did not write physician orders for restraints for any of the 11 JIRs.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>On 07/15/24 at 09:44 AM, Surveyor #2, # 3 and # 5 together interviewed the LNHA who stated that until he met with or was contacted by the New Jersey Department of Health (NJDOH), Centers for Medicare and Medicaid (CMS), and a contracted company [name redacted] he could not submit a removal plan for any of the Immediate Jeopardies because the JIRs would have to be removed from the facility and that was not possible at this time.</p> <p>On 07/15/2024 at 9:45 AM, during an interview with the Surveyor # 2 and # 3, the Licensed Nursing Home Administrator confirmed that the 11 JIRs involved residents were still being secluded and still being restrained.</p> <p>A review of the 11 JIR's Electronic Medical Record (EMR) under physician's orders did not reveal any orders for restraints. The orders did reveal a dietary order specifying that only plastic spoons are to be on the tray.</p> <p>A review of the 11 JIR's EMR under Care Plan did not reveal any focus for activities, choices, or restraints.</p> <p>NJAC 8:39-4.1</p> <p>NJAC 8:39-4.1 (6)</p> <p>NJAC 8:39-4.1 (a), 11</p> <p>NJAC 8:39-7.3(a)</p> <p>NJAC 8:39-9.2(a)</p> <p>NJAC 8:39-27.1(a)</p>