STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315236	A. Building B. Wing	05/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sinai Post-Acute Nursing & Rehab Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ186463 Based on observation, review of the medical record and other pertinent facility documents on [DATE], it was determined that the facility failed to develop a comprehensive care plan for emotional services/support for a resident who witnessed the death of another resident. This deficient practice was identified for 1 of 6 residents reviewed for care plans (Resident#2), and was evidenced by the following: On [DATE] at 12:15 PM, the surveyor interviewed Resident #2, who stated Resident #1 and an unidentified resident came to their room and all three residents were smoking crack and cocaine. According to Resident #2, they observed Resident #1 in the chair falling to the side and Resident #2 notified the Licensed Practical Nurse (LPN #1), who told the resident and the unidentified resident to leave the room. Resident #2 observed LPN #1 perform cardiopulmonary resuscitation (CPR; emergency life-saving procedure performed when someone's breathing or heart beat has stopped) on Resident #1. On [DATE] at 9:22 AM, the surveyor interviewed Resident #2, who stated their anxiety and depression was up since Resident #1 passed away, and no one spoke to the resident regarding Resident #1's death. Resident #2 further stated that due Resident #1's death, they had smoked cocaine one time that they obtained from someone from outside the facility, who brought the cocaine into the facility. Resident #2 stated they were not mentioning names, and did not provide the date, time or location they smoked the cocaine. According to the admission Record face sheet (an admission summary), Resident #2 was admitted to the facility with diagnoses which included but were not limited to; mood disorder, opioid abuse, and anxiety disorder. According to the Minimum Data Set (MDS), an assessment tool dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident's cognition was intact. The MDS also indicated that Resident #2 was independent for activities of daily living (ADLs). A review of the resident's individualized comprehensive care plan (ICCP) initiated on [DATE], did not include emotional service's or support for witnessing the death of another resident. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on [DATE] at 12:00 PM, the Social Worker (SW) stated that she spoke with Resident #2 on [DATE], and Resident #2 refused to have a conversation with her concerning the incident on [DATE], regarding witnessing the death of another resident. The SW further stated that she did not report the resident's refusal to the Director of Nursing (DON) or the Licensed Nursing Home Administrator (LNHA). During an interview with the surveyor on [DATE] at 12:10 PM, the DON stated it was the responsibility of the SW to update the care plan. The surveyor reviewed Resident #2's ICCP with the DON, who confirmed emotional support services should have been included for the resident after witnessing the death of another resident. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated revised 03/2022, indicated under Policy Interpretation and Implementation that Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. NJAC 8:39-11.2(i); 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ186463 Based on interviews, review of the medical records review and other pertinent facility documentation on [DATE] and [DATE], it was determined that the facility failed to ensure a.) adequate supervision for a Resident (Resident #1) with a known history of drug and drug paraphernalia (equipment needed for or connected with a particular activity) in the facility who had an unexpected death in the facility and was administered Narcan (drug used to reverse an opioid overdose) by nursing staff and b.) conduct and document a thorough investigation for incidents where Narcan was administered to prevent further accidents related to drug use. This deficient practice was identified for 1 of 2 residents reviewed for accidents and hazards (Resident #1), and was evidenced by the following: On [DATE] at 12:15 PM, the surveyor interviewed Resident #2, who stated on [DATE], Resident #1 and another unidentified resident came to Resident #1's room, and all three of the residents were smoking crack and cocaine. According to Resident #2, they observed Resident #1 in the chair falling to the side, so the resident notified the Licensed Practical Nurse (LPN #1), who told the resident and the unidentified resident to leave the room. Resident #2 stated they observed LPN #1 perform cardiopulmonary resuscitation (CPR; emergency life-saving procedure performed when someone breathing or heart beat stopped) on Resident #1. According to the admission Record face sheet (an admission summary), Resident #1 was admitted to the facility with diagnoses which included but were not limited to; major depressive disorder, opioid abuse, cocaine abuse, and bradycardia (slow heart rate). According to the Minimum Data Set (MDS), an assessment tool dated [DATE], Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident's cognition was intact. The MDS also indicated that Resident #1 required setup and one-person assistance with most activities of daily living (ADLs) and was independent with locomotion on and off the unit. A review of Resident #1's individualized comprehensive care plan (ICCP) included a focus area dated [DATE], that the resident had a history of poly-substance abuse. The goals included that the resident will abide by the facility's rules and policies against the use of illegal substances through the next review date. Interventions included to: obtain an order for Narcan as needed (PRN) for suspicion of illicit drug use with signs of overdose; the physician will be notified of suspicion of overdose of illicit drug; psychology consultation to develop coping mechanisms to deal with addiction; monitor for signs and symptoms of drug use and overdose; the resident to receive random room search per facility policy; and the resident will receive random toxicology screening if found. A review Resident #2's ICCP included a focus area dated [DATE], for a history of poly-substance abuse and was presently on the methadone program. The goals included that the resident will abide by the facility's rules and policies against the use of illegal substances. Interventions include to: give the resident the opportunity to vent feelings related to addiction issues; identify activities or recreation specific to the resident to provide a distraction; the resident will receive random room searches as per facility policy; the resident will receive random toxicology screenings if found; the physician will be notified of suspicion of overdose of illicit drugs; and obtain an order for Narcan (PRN) for suspicion of illicit drug use with signs of overdose. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:15 PM, the surveyor interviewed the Director of Nursing (DON), who stated that she was aware Resident #1 was found in Resident #2's room on the 6th floor nursing unit unresponsive and Narcan was administered twice by LPN #1. The DON further stated that Resident #1 had a history of substance abuse. The DON stated Resident #2's room was searched by the staff for drugs and paraphernalia, but none were found. On [DATE] at 3:29 PM, during an interview with the the surveyor, the Licensed Nursing Home Administrator (LNHA) stated he was aware of Resident #1's unexpected death. The LNHA further stated the resident had a history of substance abuse, and the supervisor searched Resident #2's room and no drugs or paraphernalia were found. The LNHA stated that the DON should have conducted an internal investigation, and the Social Worker and the Registered Nurse (RN) Supervisor should have documented the incident in progress notes and interviewed Resident #2 about the incident. On [DATE] at 3:49 PM, the surveyor interviewed LPN #1, who stated that she responded to an adult emergency services on the 6th floor in Resident #2's room, and assisted the assistant supervisor with CPR and administered Narcan to Resident #1 twice. LPN #1 stated that she did not see any drugs or paraphernalia in the room. LPN #1 further stated she was not interviewed by the LNHA about the incident. On [DATE] at 4:43 PM, the surveyor conducted a follow-up interview with the DON, who stated that staff had searched the pocket of Resident #1 and no drugs or paraphernalia were found. The surveyor asked the DON if the facility conducted an investigation, and the DON stated that an investigation was not warrant at that time. On [DATE], the surveyor received an email from the DON with the following: Summary of Investigation and copies of accident/incident employee statements. The DON stated that a random canine (K9; police dog) search would be conducted on any residents with a suspicion of drugs. If residents were out on pass and returned to the facility, security would search all their bags. If drugs were found, they would notify the DON, or the supervisor and the police would be notified and given the drugs. On [DATE] at 11:00 AM, the surveyor interviewed the DON regarding the random K9 search. The DON stated that according to the facility's Drug Screening and Searches for Resident policy, once items such as drugs, drug paraphernalia, or pills were confiscated by security, the resident's out on pass (OOP) privilege were suspended for 30 days, and they were referred for Harm Reduction Counseling. According to the random K9 search on [DATE], Resident #2 was found with drugs paraphernalia and Depakote pills (prescription medication that can be used to treat psychological disorders). Resident #2 was seen by Harm Reduction Counseling on [DATE], and OOP was suspended on [DATE], and would resume on [DATE]. A review of the facility's "Substance Abuse policy updated February 2025, included the following: Under: Policy Interpretations and Implementation: Resident identified as high risk for illegal drug use by the nursing department will be subject to have security conduct a search when returning from an authorized Out on Pass visit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:27 PM, the surveyor interviewed the DON regarding residents identified as high risk, and the DON stated Resident #2 was considered high risk, and those were residents who were found with drugs and paraphernalia. The DON stated that staff were aware those residents were high risk, and staff would frequently make rounds (every two hours) and monitor for high traffic in their room. A review of the facility's policy titled Incident and Accident Report and Investigation updated [DATE], revealed the following: Under the Policy: 1. The facility staff will document all incidents and accidents, or any unusual occurrences experienced by the resident on an Incident/Accident Report. 2. The form must be completed immediately or no later than the shift that the incident occurred or when the event has been discovered. 3. Investigations must be started as soon as the event has been reported and a final disposition/ conclusion must be completed accordingly. A review of the facility's Administrator Job Description included under Responsibilities/Accountabilities to ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individual's needs and rights . NJAC 8:39-27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Complaint #: NJ186463 Based on observation, interview, and record review, it was determined that the facility failed to ensure that a Licensed Practical Nurse (LPN) had the specific competencies and skill sets necessary to care for a resident's pain management needs. This deficient practice was identified for 1 of 6 residents reviewed for resident needs (Resident #5), and was evidenced by the following: According to Resident #5's admission Record face sheet (an admission summary), the resident was admitted to the facility with diagnoses that included but were not limited to; displaced intertrochanteric fracture of the right femur (broken hip bone at the neck of the thigh bone causing the bone to shift or separate) and unspecified fracture of sacrum (lower back). According to the Minimum Data Set (MDS), an assessment tool dated 05/14/2025, Resident #5 had severe cognitive impairment. The MDS also indicated that Resident #5 required assistance from staff for completion of their activities of daily living (ADLs). A review of Resident #5's Order Summary Report (OSR) with an admission date of 05/20/2025, included a verbal order entry for Aspercreme lidocaine external patch 4% (lidocaine); apply to right hip topically in the morning for pain management and remove per schedule. A review of Resident #5's Medication Administration Record (MAR) dated 05/21/2025, included the lidocaine order to apply to the resident's right hip topically in the morning for pain management and remove per schedule. On 05/27/2025 at 10:15 AM, the Unit Manager (UM) and the surveyor were making rounds on the residents with lidocaine patches. The UM and the surveyor observed Resident #5 had a lidocaine patch on the right thigh. The resident's physician's order indicated to apply the lidocaine patch to the resident's right hip. At that time, the UM requested the Licensed Practical Nurse (LPN) to join them in Resident #5's room, and in the presence of the surveyor, read Resident #5's lidocaine order. The LPN confirmed the lidocaine patch was on the resident's right thigh and not on the right hip. On 05/27/2025 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON), who stated the LPN should have followed the physician's order to place the lidocaine patch on the resident's right hip an not the right thigh. A review of the facility's policy titled Medication Administration dated revised April 2019, indicated . Medication are administered in accordance with prescribe orders, the individual administering the medication checks the label three (3) TIMES to verify the right resident, right medication, right dosage, right time and method (route) of administration before giving the medication . NJAC 8:39-25.2(a)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ186463 Based on interviews, review of medical records, and review of other pertinent facility documentation on [DATE] and 5/2725, it was determined that the facility failed to provide a resident with behavioral healthcare services after the resident (Resident # 2) witnessed the death of another resident in their room after allegedly using illicit drugs. This deficient practice was identified for 1 of 5 residents reviewed for resident care (Resident #2), and was evidenced by the following: A review of the progress notes revealed that on [DATE] at approximately 6:00 PM, adult emergency services was called to the 6th floor nursing unit to Resident #2's room, where Resident #1 was found unresponsive. The Licensed Practical Nurse (LPN #1) entered Resident #2's room, and found Resident #1 unresponsive. Narcan (drug used to reverse opioid overdose) was administered twice by LPN #1, cardiopulmonary resuscitation (CPR; emergency life-saving procedure performed when someone's breathing or heartbeat has stopped) was initiated, and Resident #1 was pronounced dead at 6:59 PM by Emergency Services. According to the admission Record face sheet (an admission summary), reflected that Resident #2 was admitted to the facility with diagnoses that included but were limited to; major depressive disorder, unspecified mood (affective) disorder, opioid abuse, alcohol abuse, substance-induced mood disorder, schizoaffective disorder, and anxiety disorder. According to the Minimum Data Set (MDS), an assessment tool dated [DATE], Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident's cognition was intact. The MDS also indicated Resident #2 was independent for activities of daily living (ADLs). A review of the resident's individualized comprehensive care plan (ICCP) dated [DATE], included a focus area that the resident had a history of poly-substance abuse and was presently on the methadone program. The goals included that the resident will abide by the facility's rules and policies against the use of illegal substances. Interventions included to: give the resident an opportunity to vent feelings related to addiction issues; identify activities or recreation specific to the resident to provide distraction; the resident will receive random room searches as per facility policy; the resident will receive random toxicology screenings if found; the physician will be notified on suspicion of overdose of illicit drug; and obtain an order for Narcan as needed (PRN) for suspicion of illicit drug use with signs of overdose. On [DATE] at 12:15 PM, the surveyor interviewed Resident #2, who stated Resident #1 and an unidentified resident came to their room, and all three residents were smoking crack and cocaine. According to Resident #2, they observed Resident #1 in the chair falling to the side and Resident #2 notified LPN #1, who told the resident and the unidentified resident to leave the room. Resident #2 observed LPN #1 perform CPR on Resident #1. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 9:22 AM, the surveyor interviewed Resident #2, who stated their anxiety and depression was up since Resident #1 passed away, and no one spoke to the resident regarding Resident #1's death. Resident #2 further stated that due Resident #1's death, they had smoke cocaine one time that they obtained from someone outside the facility who brought the cocaine into the facility. Resident #2 stated they were not mentioning names, and did not provide the date, time or location they smoked the cocaine. On [DATE] at 12:01 PM, the surveyor interviewed the Social Worker (SW), who stated that they spoke to Resident #2 on [DATE]. According to the SW, Resident #2 did not want to have a conversation with the SW regarding the incident. The SW stated she did not make further attempts to reach out to the resident after their refusal. The SW could not provide documentation of Resident #2's refusal for follow-up care post incident. On [DATE] at 12:10 PM, the surveyor interviewed the Director of Nursing (DON), who stated she was not aware the SW visited the resident on [DATE], and that they refused to have a conversation regarding the incident on [DATE]. The DON further stated the SW should have documented and did a Interdisciplinary Care Plan (IDCP) meeting (care plans of care created by representatives from several medical disciplines or specialties, each focus on a specific resident conditions, treatment goals, and mention for improvement outcomes) and discuss it in morning meeting. On [DATE] at 12:15 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated the SW spoke with Resident #2 on [DATE], regarding the incident, and the SW should have documented it in the progress notes. On [DATE] at 1:00 PM, the surveyor reviewed the progress notes which revealed that the Physician/Practitioner saw the resident on [DATE], and the note did not include psychosocial support. The resident was also seen by the Psychiatric Nurse Practitioner (NP) on [DATE], who recommended to start Abilify (antidepressant) 5 milligrams (mg) daily for schizoaffective disorder. A review of the facility's policy titled Incident and Accident Report and Investigation did not include a policy and procedure related to psychosocial support. A review of the facility's Social Worker Job Description included : Responsibilities/Accountabilities: 1. Work directly with residents and families experiencing personal and environmental difficulties or concerns related to the resident's physical or emotional condition. 2. Acts as a liaison between residents, families, outside agencies, and the facility Administrator to ensure that the resident's rights are maintained. 3. Ensured that residents receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals need and rights . A review of the facility's Administrator Job Description included: Responsibilities/Accountabilities: Ensures that residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individual's needs and rights . NJAC 8:39-27.1(a)