STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315344	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE CASTLE HILL	615 23RD ST , UNION CITY, New Jersey, 07087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint #s: 2673137, 2530857, 2634053, 2638934 Census: 137 Sample Size: 7 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint visit.	F0000		01/12/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of pertinent facility documents on 12/3/25 and 12/4/25, it was determined that the facility failed to thoroughly investigate by obtaining complete statements from involved staff on an incident of [redacted] of [redacted] of a [redacted], Resident #2, who was noted to have a [redacted]	F0610	ELEMENT 1 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS 2567, Statement of Deficiencies. Resident #2 remains at the facility [redacted] is well and all the [redacted] mentioned in the citation are now [redacted] ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who has the potential to sustain an injury of known and unknown origin maybe affected by the deficient practice. ELEMENT 3 What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. All reported injuries of known and/or unknown origins will be thoroughly reviewed by the Interdisciplinary Team (IDCP) headed by the DON or her designee immediately upon discovery date. Investigative process will be followed as per facility's policy; statement will be collected from the care-givers involved with caring, for the resident. If resident is alert and oriented, he/she can provide information. If conclusion	12/05/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315344	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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F0610 SS = D	Continued from page 1 NJ Ex Order 26, 4B1 On NJ Exec Order 2, Resident #2 was noticed to have a NJ Ex Order 26 [redacted]. There was NJ Ex Order 26, 4B1 and the resident NJ Ex Order 26, 4B1 to the sites. Resident #2 who was NJ Ex Order 26, 4B1 was NJ Ex Order 26, 4B1 , U. S. FO [redacted]] was informed and ordered NJ Ex Orde on the resident's NJ Ex Order 26, 4B. This deficient practice was evidenced as follows: A review of the form AAS-45, a Facility Reportable Event (FRE), a document submitted by the facility to the New Jersey Department of Health (NJDOH) on NJ Ex Order 26, 4 included the date of event: NJ Ex Order 26, no time indicated. The FRE reflected under Narrative that Resident #2 was noticed to have a NJ Ex Order 26, 4B1 [redacted]. Also a very NJ Ex Order 26, 4B1 [redacted]. There was NJ Ex Order 26, 4B [redacted] Resident was NJ Ex Order [redacted] NJ Ex Order 26, 4B noticed the NJ Ex Order 26, 4B1 during NJ Ex visit. NJ Ex O was informed and ordered NJ Ex Orde on NJ Ex Order 26, 4B The surveyor reviewed the medical record of Resident #2. A review of the Admission Record (AR) face sheet (an admission summary), revealed that Resident #2 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of the Minimum Data Set (MDS), an assessment tool, indicated the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 , which reflected a NJ Ex Order 26, 4B1 . The MDS further revealed that the resident NJ Ex Order 26, 4B1 [redacted] in the completion of their activities of daily living (ADLs). A review of the resident's Care Plan Report (CPR) included a focus: [Resident #2] has potential/actual NJ Ex Order 26, 4B1 [redacted] r/t NJ Ex history of	F0610	Continued from page 1 can be obtained from the investigative process, this will be included in the Reportable Event that will be submitted to the DOH. Resident's care plan will be reviewed by the IDCP team, new or revised care planning will completed MD and NOK will be informed of the outcome. Staff were given an in-service by the DON about the investigative process of any significant incidences that involves the resident ELEMENT 4 How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic change. All incidences with known and/or unknown causes will be reported to the DON and/ or her designee immediately after each occurrences . An audit will be conducted by the DON or her designee weekly on all injuries reported for thoroughness and completeness of investigative process. This audit will be on-going. All these incidences will be submitted by the DON or her designee to the Quarterly Committee weekly for review and recommendations.	

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F0610 SS = D	Continued from page 2 NJ Ex Order 26, 4B1 that was initiated on NJ Ex Order 26, 4B1 and revision on NJ Ex Order 26, 4B1. The CPR further revealed interventions which included but not limited to: NJ Exec Order 26.4b1, follow facility protocols for treatment of NJ Exec Order keep NJ Exec Order 26.4b1 and NJ Exec NJ Ex Order 26, 4B1 (initiated NJ Ex Order 26, 4 and NJ Ex Order 26, 4B1 (initiated NJ Ex Order 26, 4 The resident's CPR also included a focus of: [Resident #2] has NJ Ex Order 26, 4B1 as an NJ Ex Order 26, with date initiated on NJ Ex Order 26, 4B1. A review of the facility's Summary of Investigation (IS) revealed that on NJ Ex Order 26, 4 the US FOIA (b)(6) was informed about the NJ Ex Order 26, 4B1 noticed on their [Resident #2] NJ Ex Order 26, 4B1 measuring NJ Ex Order 26, 4B1 The IS further indicated there was also a NJ Ex Order 26, 4B1 on NJ Ex Order 26, 4B1 measuring NJ Ex Order 26, 4B1 . They were NJ Exec Orde to NJ Exec O the cause of NJ Ex Order 26, 4B1 The resident had NJ Ex Order 26, 4B1, nor did the resident have any NJ Ex Order 26, 4B1 . The resident did not have any NJ Ex Order 26, 4B1 to cause NJ Ex Order 26, 4B1 The resident was NJ Ex Order 26, 4B . They had very NJ Ex O . The IS further included under Conclusion: Statements were obtained from direct care-givers past 48 hours after the discovery date. There NJ Ex Order 26, 4B1 reported. There was no NJ Ex Order 26, 4B1 that occurred. The facility IS further concluded the NJ Ex Order 26, 4B1 could be NJ Ex Order 26, 4B1 to the resident's diagnosis of NJ Ex Order 26, 4B1]...the NJ Ex Order 26, 4B1 -, NJ Ex Order 26, 4B1 will be given for the resident to NJ Exec Or A review of the facility's document: Incident Report (IR NJ Ex Order) with date and time of NJ Ex Order 26, 4B1 and documented by Registered Nurse (RN) #1 and appeared as the Person Preparing Report in the IR. RN #1 was the US FOIA (b)(6) on NJ Ex Order 26, 4B1. The IR indicated under Nursing Description: Resident was NJ Ex . Observed NJ Ex Orde measuring NJ Ex Order 26 and NJ Ex Order 26, 4B1 measuring NJ Ex Order 26, 4B1 Complete assessment done NJ Ex O . NJ Ex Order 26 . NJ Ex Order 26, 4B1 . BIMS was NJ E NJ Ex Order 26, 4B1 A review of the statements obtained by the facility	F0610		

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F0610 SS = D	Continued from page 3 from staff during the investigation revealed the following: -NJ Ex Order 26, 4B1 [morning] NJ Ex Floor Unit - According to RN #2,who was assigned as one of the nurses in Unit NJ E the resident was noted with NJ Ex Order 26, . When asked if they NJ Ex Order 26, 4B1 Resident #2 said they do not NJ Exec Order 26.4b1 The U. S. FOI further indicated in their statement the resident's family was contacted, U. S. FOIA (b) (2) was contacted and supervisor was made aware. RN #2 statement did not disclosed time of incident. NJ Ex Order 26, 4B1 NJ Ex O Floor Unit - According to Licensed Practical Nurse (LPN) #1, the resident was received at NJ Ex Order 2 in bed. No report given of any incident with this resident. During 7 AM rounds, resident was seen still NJ Exec Order 26.4b1 No NJ Exec Order 26.4b1 noted from resident during the shift. -NJ Ex Order 26, 4B1 NJ Ex C Floor Unit - According to certified nursing assistant (CNA) #1, they provided care to the resident and did not notice any NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 shift NJ Ex C Floor Unit - According to RN #3, they took care of resident in their NJ Ex Order 26, 4B1 they gave medications and nothing was observed on resident. The U. S. FOIA assigned did not report anything. -NJ Ex Order 26, 4B1 NJ Ex Floor Unit - According to CNA #2, they worked NJ Ex Order 26, and did AM [morning] care on the resident [room # redacted] and found everything was NJ Ex Order 26, 4B1. NJ Ex Order 26, 4B1 shift NJ Ex C Floor Unit - According to LPN #2, they were the nurse assigned to work on the floor. Nobody reported anything to me. NJ Ex Order 26, 4B1 shift NJ Ex C Floor Unit - CNA #1 was assigned to the resident. The U. S. FOIA stated they provided care to the patient and did not NJ Ex Order 26, 4B1 on NJ Ex Order 26, 4B1. NJ Ex Order 26, 4B1 Floor Unit - According to RN #4, they worked NJ Ex Order 26, 4B and gave medications to the resident and did not observe anything on the resident. The resident was NJ Ex Orde throughout the shift. The assigned U. S. FOIA did not report anything about the resident to me. NJ Ex Order 26, 4B1 shift NJ Ex Floor Unit - According to CNA #3, they took care of the resident [name redacted] gave morning care. Their NJ Ex Order 26, 4B1	F0610		

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F0610 SS = D	Continued from page 4 There were no further statements obtained from other U. S. FOIA (b) (2)) on NJ Ex Order 26, 4B1 shift particularly a statement from the CNA [#4] assigned to Resident #2 and from staff on NJ Ex Or shift when the incident was made known on NJ Ex Order 26, 4B1 On 12/4/25 at 12:37 PM, the surveyor interviewed RN #2 regarding the incident on Resident #2. RN #2 was the assigned nurse to Resident #2 on NJ Ex Order 26, 4B1 shift. RN #2 stated at around NJ Ex Order 26, , CNA #4 (according to RN #2, the U. S. FOIA was from the agency), as they were leaving told RN #2 downstairs by the front desk that Resident #2 had a NJ Ex Order 26, 4B1 that the U. S. FOIA cannot remember where. RN #2 immediately went back upstairs and checked on the resident . The resident was in their NJ Ex Order 26, 4B1 in the dayroom. The U. S. FO further stated they then checked on the resident and noted NJ Ex Order 26, 4B1 U. S. FO asked the resident regarding the NJ Ex Order 26, 4B1 but the resident said they cannot remember. The U. S. F stated the resident was NJ Ex Order 26, 4B U. S. F then told the 3-11 shift US FOIA (b)(6) RN #2 stated that they were the U. S. FOIA (b) (2) in the other Unit but today they were assigned in the NJ Ex O Floor Unit. RN #2 further said that when they went back to the dayroom (DR), Resident #2 had their visitors with them. The U. S. F said they contacted the resident's other family member U. S. FOIA (b) (2) [name redacted]. The U. S. FOIA (b) (2) assessed the resident and notified the doctor. According to RN #2, the US FOIA (b)(6) attempted to notify the agency to get statement from the agency CNA #4 but was not able to contact the U. S. FOIA agency. On 12/4/25 at 1:11 PM, the surveyor interviewed the U. S. FOIA (b) (2) with the U. S. FOIA (b) (2) . The U. S. FOIA stated they could not remember if the CNA #4 agency was contacted U. S. FOIA remembered the US FOIA (b)(6) was trying to contact the agency. After confirming with the US FOIA (b)(6) , the U. S. FOIA stated the CNA #4 agency was not contacted but the U. S. FOIA affirmed CNA #4 never return to work in the facility. The U. S. FOIA stated CNA #4 statement was important in the investigation but they were not able to follow up. The U. S. FOIA (b stated they did the investigation and collected statements from previous shifts U. S. FOIA (b further said the statements from the U. S. FOIA (b) (2) who assigned specifically to the resident. The surveyor reiterated to U. S. FOIA (b) (2) that there were no statements from the CNA #4 who was specifically assigned to the resident. A review of the facility's policy on "Abuse, Neglect and Exploitation", under Policy: It is the policy of this facility to provide protections for the health,	F0610		

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F0610 SS = D	Continued from page 5 welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property; under Procedure:...IV. Identification of Abuse, Neglect and Exploitation:...Possible indicators of abuse include, but are not limited to: 1. Resident, staff or family report of abuse. 2. Physical marks such as bruises or patterned appearances such as a handprint, belt or ring mark on a resident's body.3. Physical injury of a resident, of unknown source...; V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion or allegation of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include; 1.Identifying staff responsible for the investigation;...4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations;...6. Providing complete and thorough documentation of the investigation. N.J.A.C. 8:39-9.4(f); Appx. B	F0610		

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 1/20/26 in relation to the 12/4/25 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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