STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE CASTLE HILL	615 23RD ST UNION CITY, NJ 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
F 000	INITIAL COMMENTS Survey date: 07/7/2022 Census: 123 Sample: 8 residents A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		

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

Electronically Signed | 07/21/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060910	A. BUILDING: _____ B. WING _____	07/07/2022

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OPTIMA CARE CASTLE HILL	615 23RD ST UNION CITY, NJ 07087

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Part A: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 2 out of 42 shifts reviewed. Findings include: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for	S 560	1. For the affected residents during the 2 of 42 shifts reviewed within Part A: The facility has engaged staffing agencies to fill unanticipated and/or emergent facility direct-care staffing needs and, will post direct-care open positions on our website and, has developed a direct care staff audit tool in order to monitor and assure minimum direct care staff-to-resident ratios are in accordance with NJAC 3:39-5.1(a). For all affected residents in Part B:	8/31/22

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

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S 560	Continued From page 1 nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every ten residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties: and (3) one direct care staff member to every fourteen residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of	S 560	Employee #1 provided evidence of a Covid-19 booster on 7/19/2022. Employee #2 provided evidence of a Covid-19 booster on 7/22/2022. Employee #3 provided evidence of a Covid-19 booster on 7/28/2022. Employee #4 was placed on inactive work status beginning 7/8/2022, and furthermore, is required to provide evidence of a Covid-19 booster shot in order to return to active work status at the facility. 2. The Facility has identified all residents having the potential to be affected by the same deficient practice. For affected residents in Part A: The facility has engaged staffing agencies to fill unanticipated and/or emergent facility direct-care staffing needs and, will actively post direct care roles on its website and the internet and, has developed a direct care staff audit tool in order to assure minimum direct care staff-to-resident ratios are monitored and followed in accordance with NJAC 3:39-5.1(a). For affected residents and reviewed employees in Part B: 3 of the 160 employees provided evidence of a Covid-19 booster shot, 1 of the 160 employees was placed on inactive work status beginning 7/8/2022, and furthermore, is required to provide evidence of a Covid-19 booster shot in order to return to active work status at the facility. 3. For Part A: The facility has developed a direct care staff audit tool to track and assure the minimum direct care	

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	060910	A. BUILDING: _____ B. WING _____	07/07/2022

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S 560	Continued From page 2 required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... During entrance conference on 7/6/22 at 8:41 AM, the Assistant Director of Nursing (ADON) in the presence of the Licensed Nursing Home Administrator (LNHA), informed the surveyor that the facility staffing was good. The LNHA stated that the facility was not using Agency staff at this time. As per the "Nurse Staffing Report" completed by the facility for the weeks of 6/19/22 to 6/25/22 and 6/26/22 to 7/2/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 06/20/22 had 13 CNAs for 120 residents on the day shift, required 15 CNAs. (9.23 residents per CNA) 06/27/22 had 13 CNAs for 124 residents on the day shift, required 15 CNAs. (9.54 residents per CNA) Part B:	S 560	staff-to-resident ratios are followed in accordance with NJAC 3:39-5.1(a). For Part B: The facility has revised their Covid-19 Vaccination Policy and Procedure and, has revised their Staff Vaccination Data Set to track all covered workers Covid-19 vaccination status and assure all covered worked are in compliance with Executive Directive 290. 4. For Part A: The facility Administrator and/or his designee will monitor minimum direct care staff-to-resident ratios by utilizing the direct care staff audit tool daily for a period of one month, then weekly for three months to assure compliance with NJAC 3:39-5.1(a). Any emergent facility direct-care staffing issues will be reported to the Director of Nursing for corrective action. For Part B: Covid-19 booster shot compliance will be reviewed by the Administrator, or his designee, by utilizing the Castle Hill Covid-19 Staff Vaccination Data Set daily for a period of one month, then weekly for three months to ensure compliance with Executive Directive 290. Any covered worker found out of compliance with Executive Directive 290 will be placed on inactive work status until compliance with Executive Directive 290 is achieved. The Direct Care Staff Ratio reports and Executive Directive 290 compliance reports will be presented to the quarterly quality assurance committee who will determine the need for continued monitoring after one quarter.	

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S 560	Continued From page 3 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to follow facility policy to ensure all staff who were eligible for their COVID-19 booster vaccination received it by 5/11/22 or within three weeks of becoming eligible. This deficient practice was identified for 4 of 160 staff members reviewed for COVID-19 vaccination booster status and was evidenced by the following: Reference: New Jersey Executive Directive 290, dated 3/2/22: 2. b. All covered workers must provide adequate proof that they are up to date with their COVID-19 vaccination by May 11, 2022; provided however, that as to having received a booster dose, covered workers must provide adequate proof that they are up to date with their COVID-19 vaccinations by May 11, 2022, or within 3 weeks of becoming eligible for a booster dose, whichever is later. During entrance conference on 7/6/22 at 8:41 AM, the Assistant Director of Nursing (DON) in the presence of Licensed Nursing Home Administrator (LNHA), stated that all staff regardless of vaccination status were tested twice per week because they are following county levels for Covid 19. Testing occurs upon entrance to the lobby of the facility. The ADON stated due to no PUI and/or positive residents, the PPEs to be used is a surgical mask in the building. She stated that anyone entering the building to visit residents who were Covid 19 positives, on PUI, and/or on observation must wear N95 masks, gowns, gloves, and goggles. The ADON stated that the Infection Preventionist (IP/RN) was in charge of the facility's COVID-19 vaccination efforts.	S 560		

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S 560	Continued From page 4 At this time, the survey team requested the facility complete the COVID-19 Staff Vaccination Matrix (VM; used to identify the vaccination status for all staff). On 7/6/22 at approximately 9:04 AM, the LNHA provided the surveyor team a document, that was not titled but included the COVID-19 vaccination status of 160 staff members. The Covid status document further revealed that 4 of 160 staff who were eligible to receive the COVID-19 booster, had not received their booster vaccination. At 11:48 AM, the surveyors met with the ADON, ICP/RN and LNHA. The surveyor asked the ICP and LNHA if they were familiar with Executive order 290. The LNHA stated, "my understanding is the two initial doses were mandatory, the boosters were not mandatory but if anyone refused, will get a disciplinary warning and would be able to continue to work." The LNHA stated they had given written warning to those staff members but did not give a specific date when the booster needed to be completed. The surveyor reviewed the Executive order 290 with the LNHA, who acknowledged their misinterpretation of the order and that any staff who have yet to receive their first booster should be taken off the schedule. The LNHA, ADON and ICP all stated they would be inform the four staff members that they need to receive their first booster. A review of the facility's testing logs, revealed that all non boosted staff members were being tested at least twice a week for COVID-19. A review of the facility's " COVID-19 Vaccination policy and procedure" dated of 3/02/22, stated:	S 560		

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S 560	Continued From page 5 12. On 1/19/22, NJ executive Order No. 283 requires all covered workers be up to date with their COVID-19 vaccination by 2/28/22 or have an approved vaccination exemption. Up to date is defined as receiving a 2 dose primary series of an mRNA COVID-19 vaccine or a single does COVID-19 vaccine, and any booster dose for which they are eligible as recommended by CDC. A disciplinary process will be implemented for any noncompliance. 13. On 3/2/22, NJ Executive Order No.290 requires that all covered workers must provide proof that they have received a booster does by 4/11/22 if eligible or within 3 weeks of becoming eligible for a booster does, whichever is later. A covered setting must take first toward bringing a noncompliant covered worker into compliance as part of a disciplinary process within 2 weeks of 4/11/22. Facility will proceed with progressive disciplinary process for those employees who are not compliant with this directive.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060910 Y1	A. Building B. Wing Y2	8/31/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE CASTLE HILL	615 23RD ST UNION CITY, NJ 07087

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/31/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/7/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO