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 _____	C 03/10/2025

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 Complaint #s: NJ 167925, 169842, 181072 Survey Date: 3/10/25 Census: 130 Sample: 27 + 1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		4/18/25

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

Electronically Signed | 03/28/2025

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 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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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) 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. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure all residents were treated in a dignified manner by failing to ensure a) residents who were NJ Exec Order 26.4b1 on staff for care were provided with NJ Exec Order 26.4b1 care prior to being served meals, and b) residents eating meals in the same dining room were served meals at the same time. This deficient practice occurred for 3 of 3 residents reviewed for dignity (Resident #31 and #42 and #129) and was evidenced by the following: On 2/27/25 at 10:16 AM, the surveyor observed Resident #129 in bed and the resident was NJ Exec Orde [redacted] and the NJ Exec Order 26.4b1 could be observed NJ Exec Order 26.4b1. The resident informed the surveyor they were last provided with NJ Exec Order 26.4b1 care at 5:00 AM. The resident	F 550	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 #129 was immediately provided with NJ Exec Order 26.4b1 care on NJ Exec Order 26.4b1 by the Certified Nurse Aide (CNA) after the resident completedthe breakfast meal. The IDCP team met with the resident to discuss the reident's preference as to the timing of the NJ Exec Order 26.4b1 care and other daily personal AM care. The CNA for Resident #129 documented the care provided to the resident on the Point of Care (POC) system.	

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F 550	Continued From page 2 informed the surveyor that they were [NJ Exec Order 26.4b1] [redacted], they could [NJ Exec Order 26.4b] [redacted], and staff would not answer the call light in a timely manner. On 2/27/25 at 10:59 AM, an [NJ Ex Order 26.4(b)(1)] observation performed with a random Certified Nursing Aide (CNA) revealed that Resident #129 was wearing an [NJ Exec Order 26.4b1] that was [NJ Exec Order 26.] [redacted] with [NJ Exec Orde] [redacted] and [NJ Exec Order] [redacted] with [NJ Exec Order] [redacted]. On 2/27/25 at 11:46 AM, the surveyor returned to Resident #129's room and the resident stated that [NJ Exec Order 26.4b1] [redacted]. The surveyor then observed that the resident had been served the lunch meal while not having been first provided with [NJ Exec Order 26.4b1] [redacted] care. On 2/27/25 at 11:50 AM, the surveyor accompanied the [US FOIA (b)(6)] [redacted] to Resident #129's room and the resident informed the nurse that they had not been provided with [NJ Exec Order 26.4b1] [redacted] care prior to the meal delivery. The [US FOIA (] [redacted] stated that the protocol was to [NJ Exec Order] [redacted] and [NJ Exec Order 26] [redacted] the residents prior to serving meals to the residents. On 2/27/25 at 12:00 PM, a review of the medical record revealed that Resident #129 was admitted to the facility with diagnoses that included, but were not limited to; [NJ Exec Order 26.4b1] [redacted]. The Admission Minimum Data Set (MDS), an assessment tool used to manage care dated [NJ Exec Order 26.4b] [redacted], reflected that Resident #129 had intact [NJ Exec Order 26.4b1] [redacted] and scored [NJ Ex] [redacted] out of 15 on the Brief	F 550	The meal distribution of resident #77, Resident #31, and Resident #42 are now arriving simultaneously. Seating arrangement and meal tray delivery are now synchronized. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All incontinent residents have that require total assistance in AM care potential to be affected by the same deficient practices. All residents who receives meal tray in the dining room have the potential to be affected by this practice. ELEMENT 3 What measures will be put into place or systemic changes will be made to ensure that the deficient practice would not recur. The Assistant Director of Nursing/Designee provided in-services to all nursing staff providing direct care on the facility's policy: 1) Observing and providing Dignity and promptness in rendering incontinency and AM care before meals especially for those who totally dependent of care; 2) Serving meals of residents simultaneously who are seated on the same table; 3) Documentation on POC (Point of Care) by the CNA when care is rendered.	

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F 550	Continued From page 3 Interview for Mental status (BIMS). The MDS also revealed Resident #129 was [redacted] on staff for most activity of daily living including [redacted]. The undated Care Plan provided by the facility on [redacted] at 10:30 AM, reflected a "[redacted] for [redacted] related to [redacted]. The goal was for Resident #129 to [redacted], [redacted] and [redacted]. The interventions were to document, report any changes, any potential for improvement reasons for [redacted]... On 2/27/25 at 12:08 PM, during an interview at with the [redacted] she stated, "the CNA would document their care in the Point of Care (POC) system." The surveyor reviewed the POC with the [redacted] and there was no documentation regarding any care provided on [redacted] for Resident #129. On 2/27/29 at 12:15 PM, the surveyor interviewed the CNA who cared for Resident #129. The CNA stated that she served breakfast that morning to the resident and confirmed that she did not provide any care to the resident. She stated she was "Agency Staff" and was not informed of what was to be done for the resident. 2. On 2/28/29 at 11:40 AM, the surveyor observed the lunch meal pass on the [redacted] floor. The surveyor observed three residents seated in the right corner of the room that was adjacent to the nursing station. The surveyor observed a [redacted] set up the lunch tray for Resident #77. Resident #77 began eating their lunch meal while Resident #31 and #42 watched television and waited for their trays. The surveyor observed that both	F 550	Ten (10) residents will be observed weekly x 4 weeks by the Unit Manager/designee: 1) ensure that staff are treating them in a dignified manner, incontinency care are rendered prior to meals; 2) Simultaneous Meal distribution of 10 residents eating in the dining room will be observed 3x week for the next 4 weeks. 3) Documentation in POC of care rendered to residents. 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. The Director of Nursing/designee will review the results of observation to determine if staff are maintaining and promoting resident dignity, Meal distribution and documentation in POC. The results of these observations will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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F 550	Continued From page 4 residents waited 25 minutes before they received their lunch meals. Resident #31 and #42 received their lunch meal at 12:05 PM. On 3/04/25 at 11:20 AM, the surveyor again observed the lunch meal on the [redacted] floor. The first lunch cart arrived on the floor at 11:24 AM. The surveyor observed 3 residents seated in the right corner of the room same as on 2/28/25. On 3/04/25 at 11:34 AM, the surveyor observed Resident #77 received their lunch meal. The [redacted] set-up the lunch meal for the resident and left the room. Resident #77 was eating their lunch and Resident #31 and #42 were actively watching Resident #77 eating while waiting for their trays. Resident #77 completed their meal at 11:45 AM. Resident #31 and #42 received their trays at 12:01 PM. On 3/4/25 at 12:50 AM, the surveyor interviewed the [redacted] assigned to the unit regarding the above observation. The [redacted] stated, "The trays arrived at different times, and Residents should be fed at the same time while seated at the same table." The surveyor then asked the [redacted] if it was normal practice for residents to sit and observe other residents eating their meals. The [redacted] stated, "I agreed with you, they should be served at the same time, it is what it is." The surveyor then reviewed Resident #31's medical record which revealed the resident was admitted to the facility with diagnoses that included, but was not limited to; [redacted]. According to the most recent MDS, dated [redacted], Resident #31 had [redacted]	F 550		

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F 550	Continued From page 5 NJ Exec Order 26.4b1 and required staff assistance with NJ Exec Order 26.4b1. Resident #31 scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS) which indicated a NJ Exec Order 26.4b1 . The surveyor reviewed Resident #42's medical record which revealed diagnoses which included, but were not limited to; NJ Exec Order 26.4b1 . The Quarterly Minimum Data Set (MDS) dated NJ Exec Order 26.4b, reflected that Resident #42 was NJ Exec Order 26.4b1 . Resident #42 scored [redacted] out of 15 on the Brief Interview for Mental Status (BIMS). On 3/05/25 at 10:16 AM, during an interview with the US FOIA (b)(6) regarding the above concern, she stated that the staff had since been in-serviced. On 3/6/25 at 1:30 PM, the surveyor discussed the above concerns with the US FOIA (b)(6) who stated that the facility had been educated and the facility did not have a related policy for dining.	F 550		
F 558 SS=D	NJAC 8:39 - 17.4(d) Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 558	ELEMENT 1	4/18/25

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F 558	Continued From page 6 review it was determined that the facility failed to ensure a resident who required assistance with Activities of Daily Living (ADLs) had all necessary items maintained within reach of the resident. This deficient practice was identified for 1 of 1 resident (Resident #129) reviewed for accommodation of needs and was evidenced by the following: On 3/5/25 at 9:15 AM the resident was not available in their room, and at that time the surveyor reviewed the electronic medical record which revealed: a Progress Notes dated [redacted] timed 11:50 PM: Interdisciplinary Team Note. Note Text: Resident [redacted] at around 10:15 PM. According to the resident, the staff failed to place the bedside table within the resident's reach. While attempted to reach for the phone the resident [redacted], [redacted] of [redacted] in their [redacted]. The resident was transferred to the Emergency Department for evaluation and returned to the facility on [redacted]. [redacted] and [redacted] performed at the hospital were [redacted] The Admission Record revealed Resident #129 was admitted to the facility with diagnoses which included, but were not limited to; [redacted] and [redacted] and [redacted]. The Admission Minimum Data Set (MDS), an assessment tool used to manage care dated [redacted] reflected that Resident #129 had [redacted] as evidenced by a [redacted] out of 15 score on the Brief Interview for Mental status (BIMS). Resident #129 was [redacted] on staff for most activity of daily living which included [redacted] The Comprehensive	F 558	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. In the process of rendering AM care and/or during med administration that bed side table, call bells and other personal items needed by resident #129 with [redacted] of [redacted] was [redacted] and [redacted] for resident #129. On 3/7/2025, the Unit Manager corrected this issue immediately and ensured that Resident 129's bedside table (with the phone and personal items) and call bell were within reach of the resident. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents requiring total assistance with Activities of Daily Living (ADLs) and requires personal and necessary items within their immediate reach have the potential to be 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 would not recur.	

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F 558	Continued From page 7 undated care plan provided by the facility on [NJ Exec Order 2] at 12:30 PM, reflected a "Focus" for [NJ Exec O] related to [NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1 [redacted]. The goal was for Resident #129 not to NJ Exec Order 26.4b1 through the review date. The interventions were to anticipate and meet needs, Be sure call light is within reach, and encourage to use it for assistance as needed. Provide prompt response to all requests for assistance. On 03/06/25 at 8:51 AM, the surveyor observed the resident was in bed and the resident informed the surveyor that they [NJ Exec] and had reported [NJ Exec O] on the [NJ Exec Order 26.4b1]. When asked to elaborate regarding the [NJ Exec] Resident #129 stated in the presence of the US FOIA (b)(6) [redacted], that prior to providing care the US FOIA (b)(6) [redacted] moved the bedside table away, and that was where the resident's phone was, and the [US FOIA (b] did not move the bedside table back where it was originally located, next to the bed. Resident #129 stated then the nurse came to administer medications, and walked away before they could asked to move the bedside table close to the bed. The resident's phone was ringing and ringing, they attempted to reach for the phone, and could NJ Exec Order 26.4b1 [redacted] Resident #129 added that was not the first time that the phone had been placed of their reach and they could not answer the phone. The resident further stated, NJ Exec Order 26.4b1 I felt [NJ Exec Order 26.4] because the bedside table was placed near the door with the phone, and I NJ Exec Order 26.4b1 the phone". On 03/07/25 at 11:00, during the exit conference held with the US FOIA (b)(6) [redacted],	F 558	The Assistant Director of Nursing /Designee educated all nursing staff on 03/17/2025 on the need to ensure that residents who require assistance with Assistance of Daily Living (ADLs) had all necessary items maintained within reach of the resident. Audits will be conducted by Unit Manager/Designee to ensure implementation of care plan interventions to accommodate residents needs. Audits will be conducted for 10 (ten) residents who require assistance with ADLs daily for 1 week, then 5 (five) residents weekly x 4 weeks. 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. The Director of Nursing/designee will review the audit results weekly to determine if facility staff performing and documenting activities related to functional maintenance program. The results of these observations will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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F 558	Continued From page 8 US FOIA (b)(6) [redacted] The [redacted] confirmed that staff who provided care should move items back within reach of the residents and the [redacted] confirmed that was not the first time that items have been left out of reach of Resdient #129.	F 558		
F 609 SS=E	NJAC 8:39-27.1(a) Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §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	F 609		4/18/25

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F 609	Continued From page 9 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # NJ 167926 Based on interview, record review and document review it was determined that the facility failed to report an NJ Exec Order 26.4b1, and [redacted] to the Department of Health (NJDOH) as required within two hours of the [redacted] being made. The deficient practice was evidenced for 2 of 4 resident reviewed for investigations (Resident #343 and #290) and was evidenced by the following: 1. On 2/28/25 at 12:05 PM, Surveyor #1 observed Resident #343, sitting in the room in a wheelchair. The surveyor observed the right side of the resident's face with [redacted] and a [redacted] around their [redacted] On 3/4/25 at 12:29 PM, Surveyor #1 reviewed the medical record for Resident #343. A review of the Admission Record face sheet (an admission summary) reflected that Resident #343 was admitted to the facility with diagnoses which included but were not limited to; [redacted]. A review of an Annual Minimum Data Set (MDS) an assessment tool used to facilitate the management of care dated [redacted], reflected that Resident #343 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicative of [redacted].	F 609	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 343 was transferred to the hospital on [redacted] and remained in the hospital to the present. Resident 290 was [redacted] from the facility to home with the resident's family on [redacted]. A letter in response to the resident's grievance about the quality of care was sent to the Health Insurance Company on [redacted] wherein the resident was a member. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents who may be involved in an allegation of abuse, neglect, exploitation or mistreatment including sustaining injuries of unknown origin and are required to be reported to the State Survey Agency within the appropriate timeframe established by the State law have the potential to be affected by this deficient practice.	

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F 609	Continued From page 10 A review of the electronic Progress Notes (PN) dated [redacted] at 10:30 AM, reflected that the resident was noted with a [redacted]. The PN reflected that the resident was assessed, vital signs were [redacted] Resident #343 was scheduled for [redacted] treatment that day, left the facility for [redacted] and returned at 4:57 PM. Upon return from the [redacted] center, the [redacted] who assessed the resident, indicated that the [redacted] had [redacted] in [redacted] the [redacted] was made aware. The Physician was notified and ordered to transfer the resident to the Emergency Department for evaluation and treatment. The Resident Representative was made aware of the transfer. A [redacted] performed at the hospital was [redacted] for [redacted] according to the facility. Resident #343 returned to the facility on [redacted] at 11:55 PM. On 3/5/25 the surveyor requested the investigation for review. On 3/5/25, the [redacted]) provided the surveyor with a copy of the Reportable Event Record/Report dated [redacted]. The incident was reported to the New Jersey Department of Health (NJDOH) on [redacted] at 4:30 PM (3 days later). On 3/7/25 at 11:52 AM, the surveyor interviewed the [redacted]. The [redacted] acknowledged to the survey team that she was made aware of the incident late in the evening,	F 609	ELEMENT 3 What measures will be put into place or systemic changes will be made to ensure that the deficient practice would not recur. All staff were given an in-service on 3/19/2025 about immediate reporting of any allegations of abuse, neglect or mistreatment including discovery of injury of unknown injury. Administration, nursing management or designee reviewed the regulation and enforcement of 483.12 (c) on the timeliness of reporting to the State Survey Agency. Return understanding and competency of enforcement were included in the education process. An audit of potential reportable events will be conducted by the Administrator/designee weekly x 5 weeks. 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. Results of this audit will be forwarded to the QA committee quarterly for review and any recommendation.	

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 _____	C 03/10/2025

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although the incident occurred at 10:00 AM that day. She informed the surveyor that the [US FOIA (b)(6)] was in charge of the investigation and reported the incident to the NJDOH. She could not provide the rationale for reporting the incident 3 days later while the survey team was on site.

2. On 2/28/25 at 12:55 PM, upon an inquiry from Surveyor #2, the [US FOIA (b)(6)] stated there were no investigations for Resident #290 related to care concerns, however, then provided Surveyor #1 with copies of progress notes beginning [NJ Exec Order 26.4].

On 3/04/25 at 9:06 AM, the [US FOIA (b)(6)] stated she had an investigation regarding Resident #290, and then confirmed that nothing was reported the NJDOH. The surveyor reviewed the following:

A Grievance/Concern Form revealed: Description of Concern: Resident reported to [US FOIA (b)(6)]) on 11:00 AM on [NJ Exec Order 26.4b] that while in [NJ Exec Order 26.4] the resident had a [NJ Exec Order] in [NJ Exec Order] and asked the [US FOIA (b)(6)] to bring them to their room to be [NJ Exec Order 26.4b1]. Resident #290 stated, three Certified Nurse Aides (CNAs) assisted them and "I was [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] to the bathroom, as I was [NJ Exec Order 26.4b] to put [NJ Exec Order 26.4b1] to be [NJ Exec Order 26.4b] because I am [NJ Exec Order] Another Grievance/Concern Form revealed: Concern Reported To: IDC [Interdisciplinary Care Team] [US FOIA (b)(6)] Description of Concern: Resident #290 requested a meeting with the IDC team and was [NJ Exec Order 26.4b1] due to many issues but the in particular the treatment they received from two CNAs last Friday [NJ Exec Order 26.]. The resident claimed they [NJ Exec Order 26.4b1] and needed to be [NJ Exec Order 26.4b1]

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F 609	Continued From page 12 Resident #290 stated both CNAs were NJ Exec Order 26.4b1 in the process and one CNA was NJ Exec Order 26.4b1 and the CNAs NJ Exec Order 26.4b1. On 3/07/25 at 8:50 AM, Surveyor #1 interviewed the US FOIA (b)(6) in the presence of the survey team. The US FOIA (b)(6) confirmed that Resident #290's documented NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1 of NJ Exec Order 2 and confirmed they were not reported to the NJDOH. Surveyor #1 asked the US FOIA (b)(6) if there was any reason the NJ Exec Order 26.4b1 were not reported to the NJDOH and the US FOIA (b)(6) had no comment. The Abuse, Neglect and Exploitation policy, signed by the US FOIA (b)(6) on 5/25/24 revealed: VII: Reporting/Response: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specific timeframes: a. immediately, but not later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. NJAC 8:39- 9.4(f)	F 609		
F 610 SS=E	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,	F 610		4/18/25

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F 610	Continued From page 13 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: Complaint # NJ 167926 Based on observation, interview, record review and review of pertinent documents it was determined that the facility failed to complete a thorough investigation to rule out [redacted] or [redacted] for a resident who sustained an [redacted], for an [redacted] of [redacted] and ensure a resident was protected from potential [redacted] while an investigation was completed. This deficient practice occurred for 2 of 4 residents reviewed for [redacted] (Resident #290 and Resident #343) and was evidenced by the following: 1. On 2/28/25 at 12:05 PM, Surveyor #1 observed Resident #343 sitting in the wheelchair in their room. Surveyor #1 observed the right side of the resident's face with [redacted] of [redacted] and a [redacted] around their [redacted] On 03/04/25 at 12:29 PM, Surveyor #1 reviewed the Medical Record (MR) for Resident #343 which revealed the following: The Admission Record revealed the resident was admitted to the facility with diagnoses which	F 610	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 343 was transferred to the hospital on [redacted] due to [redacted] and remained in the hospital to the present. Resident 290 was discharged from the facility to home with the resident's family on [redacted]. A letter in response to the resident's grievance about the quality of care was sent to the Health Insurance Company on 10/15/23 wherein the resident was a member. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents who may be involved in an	

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F 610	Continued From page 14 included, but were not limited to; NJ Exec Order 26.4b1 [redacted] The Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26. , reflected that the resident had a Brief Interview for Mental Status (BIMS) score NJ Ex out of 15 that indicated the resident had NJ Exec Order 26.4b1 . The Care Plan (CP) revealed a focus area initiated NJ Exec Order 26.4b that revealed Resident #343 had NJ Exec Order 26.4b1 an NJ Exec Order with NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 . Interventions included NJ Exec Order 26.4b1 for 24 hours. A review of the Nursing Progress Notes (PN) dated NJ Exec Order 26 at 10:30 AM revealed the following: RN #1 was called into resident's room by RN #2 and the US FOIA (b)(6) to show the NJ Exec Orde on Resident #343's head. RN #1 asked the resident how it happened, and the resident stated that while in the chair, they were NJ Exec Order 26.4b1 . The US FOIA (b called for help and RN #2 and the US FOIA (b both assisted the resident NJ Ex Order 26.4(b)(1 the chair. The PN revealed that when RN #1 assessed the resident, the resident 'NJ Exec Order 26.4b1 " and was NJ Exec Orde RN #1 checked resident's vital signs (VS/ blood pressure, pulse, respirations, temperature and pain). The US FOIA (b)(6) was made aware of the incident after it occurred. On 3/5/25 at 8:31 AM, the surveyor requested any facility's incidents, investigations, reportable events that were sent to the New Jersey	F 610	allegation of abuse, neglect, exploitation or mistreatment including sustaining injuries of unknown origin have the potential to be affected by this deficient practice of not completing a thorough investigation. ELEMENT 3 What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All licensed staff were given in-service by the DON or her designee on 03/19/2025 about the process of thorough investigation of allegations of abuse, neglect, mistreatment and including discovery of injury of unknown origin. Return understanding and competency were initiated DON/designee after each education. An audit of potential reportable events will be conducted by the Administrator/designee weekly x 5 weeks. 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 investigations of allegations of abuse, neglect or mistreatment including injury of unknown origin will be thoroughly reviewed by the DON/designee	

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F 610	Continued From page 15 Department of Health (NJDOH) and any grievances for February 2025. On 3/5/25 at 10:07 AM, Surveyor #1 interviewed the US FOIA (b)(6) regarding the NJ Exec that occurred for Resident #343. The US FOIA (b)(6) stated she was made aware of the NJ Exec on NJ Exec Order 26. around 12:00 PM, which was after the morning meeting. At that time, the US FOIA (b)(6) stated she was unable to complete an assessment of the resident, as the resident had already left the building for NJ Exec Order 26. treatment. The resident then returned from NJ Exec Order 26. at 4:57 PM and the US FOIA (b)(6) was made aware by the US FOIA (b)(6)) on duty that the NJ Exec Order 26.4b1) was observed on the NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1. On 3/5/25 at 11:32 AM, Surveyor #1 interviewed RN #1 regarding the NJ Exec RN #1 stated she had asked the US FOIA (b to assist the resident to get the resident ready for NJ Exec Order 26 on NJ Exec Order 26.4b1 RN #1 stated the resident was already sitting in the wheelchair and RN #1 had been passing medications on the opposite hallway. The US FOIA (b then exited out of Resident #343's room and called for help, and then RN #2 went to help and assisted the US FOIA (b to NJ Exec Resident #343 NJ Exec Ord into the wheelchair as the resident was NJ Exec Order 26.4b1. RN #1 then stated RN #2 informed her that he had observed the resident sitting on the edge of the wheelchair. RN #1 stated that RN #2 told her that they assisted the US FOIA (b to NJ Exec the resident NJ Exec Ord into the wheelchair and at that time had observed a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 of Resident #343's NJ Exec Order 26.4b1 RN #1 stated that RN #2 then asked them to check on the resident because of the observed NJ Exec Order 26.4b1. RN #1 stated that she assessed Resident #343's vital signs and	F 610	immediately as it occurs. Results of the investigation will be forwarded to the Administrator when completed then subsequently to the QA committee quarterly for review and further recommendation.	

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NJ Exec Order 26.4b1 and then the resident was sent out for NJ Exec Order 26 at their scheduled time. RN #1 stated she contacted the US FOIA (b)(6) via text message.

On 3/5/25 at 11:55 AM, Surveyor #1 reviewed the facility provided Investigation for the incident that occurred on NJ Exec Order 26.4b included the following statements:

A statement signed by RN #1, dated NJ Exec Order 26.4b revealed ... that called by other nurse on NJ Exec O side and the US FOIA (b who showed the "NJ Exec Order 26.4b1" ... "NJ Exec Order 26.4b1" ... the US FOIA (b)(6) was made aware after the incident ...

A statement completed by RN #2 dated NJ Exec Order 26. revealed ... I was called by the US FOIA (b to assist with NJ Exec Order 26.4b1 patient who was at the edge of the wheelchair after NJ Exec Order 26.4b the patient NJ Exec Ord into the chair "I observed a NJ Exec Orde on NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 when I asked if the patient had NJ Exec Ord NJ Exec O said NJ Exe and notified the nurse the changes of the patient and to follow up. The patient left the unit at 11:00 AM for NJ Exec Order 26 and returned at 4:00 PM with "a more NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 the supervisor was informed ... and [primary medical doctor] was informed ...the patient will be transferred to the hospital for further evaluation and treatment."

A statement from the US FOIA (b dated NJ Exec Order 26.4 revealed ... at 9:45 AM the nurse informed me that the resident was going out at 10:00 AM to NJ Exec Order 26. and wanted me to get the resident NJ Exec Order 26.4b . When got to the room the resident was already NJ Exec Order 26.4b and sitting in the wheelchair with back to

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the door. I asked if the resident was [NJ Exec] and needed to be [NJ Exec Order 26.4b] and the resident responded, "I [NJ Exec Order 26.4b1]." I then made my way to the bathroom with the resident in wheelchair and as I approached the bathroom I noticed the resident started [NJ Exec Order] and "[NJ Exec Order 26.4b1]. I then went to get help from the nurse for a "minute or so" so the nurse can help me get the [NJ Exec Order 26.4b1]. When the resident was [NJ Exec Or] in the wheelchair "I noticed [they] had a [NJ Exec Order 26.4b1], the nurse took a photo. I am not sure if the resident attempted to get up front [NJ Exec] wheelchair on [their] own while I went to get help and [NJ Exec Order 26.4b1] on the [NJ Exec Order 26.4b1] wheelchair because at that time there was nothing around [NJ Exec] that [they] could use to [NJ Exec Order 26.4b1]"

The [US FOIA (b)(6)] completed a statement dated [NJ Exec Order 26.4] that revealed "on [NJ Exec Order 26.4], received a text from RN #1 that resident #343 had a [NJ Exec Orde] on [NJ Exec Orde] on [NJ Exec Order 26.4b1]. I was in morning report at that time and I did not check my text messages. I got out of morning report at 12:05 PM and upon arrival RN #2 informed me of incident and resident was not at facility as left for [NJ Exec Order 26.4b] At 4:18 PM, I received a call from RN #2 that Resident #343 had returned and assessed patient. "Called to notify [US FOIA (b)(6)] who gave order to send out resident for [NJ Exec Order 26.4b1] of the [NJ Exec Orde] [NJ Exec Order 26.4b1] ...

A statement dated [NJ Exec Order 26.4], signed by two social workers revealed they met with Resident #343 and documented: resident stated that [NJ Exec] from the chair in the bathroom on Tuesday around 8:00 AM. CNA was with the resident when [NJ Exec] and

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[redacted] called another person to help pick up ...

A Reportable Event Record submitted to the NJDOH on [redacted] at 4:30 PM, revealed an undated Summary of Investigation for the Date of Event: [redacted] revealed: On [redacted] [no time indicated] the [redacted] brought Resident #343 to get ready for [redacted] "While Resident #343 was being wheeled to the bathroom door, the resident began to [redacted] and [redacted] leaning [redacted] at this time the [redacted] decided to leave in that position to summon assistance in [redacted] to wheelchair." There investigation failed to identify a causal factor for the [redacted], what initially led to the resident [redacted] of the chair, how long the resident was left [redacted] on [redacted], and why the physician was not immediately notified of the identified [redacted] prior to being transported to [redacted]

On 3/6/25 at 8:36 AM, Surveyor #1 attempted to call RN #2 for an interview regarding the [redacted] and RN #2 was not available for the interview.

On 3/6/25 at 10:39 AM, Surveyor #1 completed a telephone interview with the [redacted] regarding the [redacted] The [redacted] stated she did not observe the [redacted] but the resident told her that they [redacted]

On 3/6/25 at 11:00 AM, in the presence of the survey team, Surveyor #1 asked the the [redacted] if the investigation that was provided complete and the [redacted] confirmed that the investigation that was provided to Surveyor #1 was complete. Surveyor #1 asked the [redacted] about the facility's investigative process. The [redacted] stated the supervisor would start the investigation and obtain statements from anyone involved with

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the resident care and also including the roommate, the resident and the supervisor would completed a summary. The [US FOIA (b)] stated "usually they would go back 48 hours if the [NJ Exec Orde] was identified as an NJ Exec Order 26.4b1 ." The [US FOIA (b)] then stated, "not even close" with the amount of statements that should have been received from staff regarding the investigation. The [US FOIA (b)] further stated she had interviewed the night supervisor from previous shift to inquire if there were any incident that happened during the night; however, the [US FOIA (b)] could not provide any statements collected from the night shift staff. The [US FOIA (b)] stated that the responsible party (RP) were present when the social workers interviewed the Resident and the RP stated the resident was not "comprehending anything." When the [US FOIA (b)] was asked if she had been notified of the [NJ Exec Order] she stated that she was made aware late in the afternoon after the resident had returned from [NJ Exec Order 26.] and she did not know when the physician and RP's were notified. The surveyor asked why the staff did not follow-up after not receiving a response to the text, the [US FOIA (b)] stated, "exactly, I don't know why." The surveyor asked the [US FOIA (b)] if the resident had [NJ Exec Orde] on the floor and the [US FOIA (b)] stated, "don't know."

On 3/6/25 at 12:23 PM, in the presence of the survey team, Surveyor #1 interviewed the US FOIA (b)(6)) who was in charge of the investigation. The [US FOIA (b)(6)] stated the staff observed the resident in the morning prior to the [NJ Exec Order 26.] treatment with a [NJ Exec Order 2] and a [NJ Exec Orde] on the [NJ Exec Order 26.4b1] and stated the [US FOIA (b)] did not know when it happened. Upon return from the [NJ Exec Order 26.4b] RN #2 assessed the resident and reported that the [NJ Exec Order 26.4b1] had NJ Exec Order 26.4b1. The physician was then made

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F 610	Continued From page 20 aware and gave order to transfer the resident to the Emergency Department for evaluation and treatment. 2. On 2/28/25 12:41 PM, Surveyor #2 asked the US FOIA (b)(6)) about recalling Resident #290 during NJ Exec Order 26.4b1 and asked about any investigations completed while the resident was at the facility. The US FOIA (b)(6) stated she recalled Resident #290, but there were no investigations at all, there were no grievances from the resident and there was nothing reported to the DOH regarding Resident #290. On 2/8/25 at 12:55 PM, the US FOIA (b)(6) stated there were no investigations for Resident #290, however, then provided Surveyor #1 with copies of progress notes beginning NJ Exec Order 26.4. On 3/4/25 at 8:30 AM the surveyor reviewed the Electronic Medical Record for Resident #290 which revealed: the Admission Record indicated the resident had diagnoses including, but were not limited to; NJ Exec Order 26.4b1 , a NJ Exec Order 26.4b1 Follow Up Note, dated NJ Exec Order 26.4b1 revealed the resident was admitted for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and "presents NJ Exec Or and NJ Exec Order 26.4b1 NJ Exec Order 26.4b reports, I feel a little bit NJ Exec Orde and I'm going to NJ Exec Order 26.4 but I still feel NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 no signs and symptoms of NJ Exec Order 2 or NJ Exec Order 26.4b1 noted at that time. On 3/04/25 at 9:06 AM, the US FOIA (b)(6) stated she had an investigation regarding Resident #290, and then confirmed that nothing had been reported the NJDOH. The surveyor reviewed the following: Grievance/Concern Form revealed: Description of	F 610		

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	315344	A. BUILDING _____ B. WING _____	C 03/10/2025

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Concern: Resident reported to US FOIA (b)(6)) on 11:00 AM on 09/16/23, that while in NJ Exec Order 26. the resident had a NJ Exec Order movement in NJ Exec Order 2 and asked the NJ Exec Order 26.4b to bring them to their room to be NJ Exec Order 26.4b1 Resident #290 stated, three Certified Nurse Aides (CNA #1, #2 and #3) assisted them and "I was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the bathroom, as I was NJ Exec Order 26.4b to be NJ Exec Order 26.4b1 to be NJ Exec Order 26.4b because I am NJ Exec Order 2 The Actions taken to resolve the concern and the Results of the action taken part of the form were both left blank and the form was signed by the US FOIA (b and dated NJ Exec Order 26.4b

The following attached employee statements revealed:

Employee Name: CNA #1, Dated NJ Exec Order 26.4b Date incident occurred/found: NJ Exec Order 26.4b1 Description of the Incident/Accident: On NJ Exec Order 26.4b1 I went to help CNA #2 with Resident #290 to put the resident on the NJ Exec Or and NJ Exec Order 26.4b1, the resident said to NJ Exec Order 26. them in the bed and NJ Exec , and CNA #2 and #3 changed them; CNA #2, Dated NJ Exec Order 26. , Date incident occurred/found: [left blank]. Description of the Incident/Accident: went with CNA #1 and #3 to put resident NJ Ex Order 26.4(b) but couldn't do it and put in bed and NJ Ex Order 26.4(b)(1); CNA #3, Dated NJ Exec Order 26. , Date/ shift assigned as caregiver: NJ Exec Order 26.4b Date incident occurred/found: NJ Exec Order 26 , 7:00 AM to 3:00 PM, Description of the Incident/Accident: Friday around 2:25 PM, Resident #290 NJ Ex Order 26.4(b)(1). I went to room, told me needed to have NJ Exec Order 2 I called my coworkers to help to put on the NJ Exec Or but resident could not do it and NJ Exec Order 26.4b NJ Exec Order 26 There was no statement from the resident included in the documents provided by the US FOIA (b)(6)

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Another document provided by the [US FOIA (b)(6)] dated [NJ Exec Order 26.4b1], was a grievance from Resident #290's Health Insurance Company (HIC). The document revealed Resident #290 [NJ Exec Order 26] that was '[NJ Exec Order 26.4b1] ". The resident [NJ Exec Order 26] that they had an '[NJ Exec Order 26.4b1] while at [NJ Exec Order 26.4b1] and needed to be [NJ Exec Order 26.4b] due to [NJ Exec Order 26.4b1] in [NJ Exec Order 26.4] stated they were sitting when 3 aides [Names redacted of CNA #1, #2 and #3] came to clean the resident and when they tried to [NJ Exec Order 26.4] from the chair, and when they realized that, [Resident #290] had an [NJ Exec Order 26.4b] they [NJ Exec Order 26.4b1] in the resident's room. They were being [NJ Exec Order 26.4b1] with the resident and [NJ Exec Order 26] the resident to [NJ Exec Order 26.4b] on their own, also the resident stated that they were [NJ Exec Order 26.4b1]. Resident #290 [NJ Exec Order 26] that the CNAs did [NJ Exec Order 26.4b1] and the CNAs told him/her '[NJ Exec Order 26.4b1] and another CNA told him/her [NJ Exec Order 26.4b1] once they got him/her on their bed."

On 3/5/25 at 12:00 PM the [US FOIA (b)(6)] provided Surveyor #2 with the requested CNA assignment sheets for [NJ Exec Order 26.4b1] which revealed: CNA #3 was assigned to Resident #290 on [NJ Exec Order 26.4] [CNA #2 also worked on the same unit], [NJ Exec Order 26.4b] [CNA #1 and #2 also worked on the same unit]. On [NJ Ex Order 26.4(b)], two days after Resident #290 reported CNA #1, CNA #2 and CNA #3 [NJ Exec Order 26] and [NJ Exec Order 26.4b1] wheeled then back to bed to be [NJ Ex Order 26.4(b)(] because the resident was [NJ Exec Orde] CNA #3 was again assigned to Resident #290.

On 3/07/25 at 8:50 AM, Surveyor #2 interviewed the [US FOIA (b)(6)] in the presence of the survey team and

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the reviewed the [NJ Exec Order 26.4b1] that Resident #290 made to the [US FOIA (b)(6)] on [NJ Exec Order 26.4] and asked the [US FOIA (b)(6)] if the [NJ Exec Order 26.4b1] constituted [NJ Exec Order 26] and the [US FOIA (b)(6)] confirmed that Resident #290's documented [NJ Exec Order 26.4b1] were [NJ Exec Order 26.4b1] of [NJ Exec Order 26] Surveyor #2 asked the [US FOIA (b)(6)] what should immediately happen, per facility policy, after an [NJ Exec Order 26.4b1] of [NJ Exec Order 2] is made. The [US FOIA (b)(6)] stated "remove the CNA involved" and the surveyor asked if that had occurred and the [US FOIA (b)(6)] stated, "I don't think so." Surveyor #2 asked again if it was an [NJ Exec Order 26.4b1] of [NJ Exec Order 2] and the [US FOIA (b)(6)] responded, "yes." There was no evidence that the CNAs were removed and did not have access to Resident #290.

On 3/07/25 at 11:00, during the exit conference held with the [US FOIA (b)(6)], there was no additional information provided.

The Abuse, Neglect and Exploitation policy, signed by the [US FOIA (b)(6)] on 5/25/24 revealed: Policy: It is the policy of this facility to provide protections for the health, 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's property. V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. 4. Identifying and interviewing all involved persons, including the alleged victim ...witnesses, and others who might have knowledge of the allegations. 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment

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F 610	Continued From page 24 has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. VI: Protection of the Resident: The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation, D. Room or staffing changes ... A review of the facility's "Unexplained injuries" policy revised date 11/22, included that all unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated.	F 610		
F 640 SS=D	NJAC 8:39- 4.1(a)12 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days	F 640		4/18/25

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F 640	Continued From page 25 after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to complete and transmit the required Material Data Set (MDS) assessment for 1 of 1 system selected MDS assessments reviewed and was evidenced by the following:	F 640	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	

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F 640	Continued From page 26 On 3/4/25 at 10:05 AM, the surveyor reviewed the medical record for Resident #83. The MDS record revealed that the Resident was discharged on [NJ Exec Order 26.] and the MDS record was identified as 132 days overdue. On 03/04/25 at 10:51 AM, the surveyor interviewed the [US FOIA (b)(6)] regarding the MDS process when a resident was discharged. The [US FOIA (b)(6)] stated the facility must complete a discharge MDS, and she stated it is usually completed immediately. The surveyor asked the [US FOIA (b)(6)] to review Resident #83's MDS in the presence of the surveyor. The [US FOIA (b)(6)] reviewed the MDS and stated, "I must have missed this one" and the surveyor requested a Validation report for Resident #83's MDS. On 03/05/25 at 8:31 AM , the [US FOIA (b)(6)] provided a copy of the Final Validation Report, dated 3/4/25, which revealed. Assessment Completed Late: Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date). NJAC 8:39- 11.1	F 640	Deficiencies. Resident #83 [NJ Ex Order 26.4(b)(1)] in the facility. Minimum Data Set (MDS) discharge assessment was completed and transmitted by the MDS Coordinator on [NJ Exec Order 26] On 3/10/2025, the MDS Coordinator audited all discharges in the last 30 days to ensure timely completion and transmission of the discharge assessments. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents discharged from the facility have the potential to be affected by the alleged deficient practice. ELEMENT 3 What measures will be put into place or systemic changes will be made to ensure that the deficient practice would not recur. On March 17, 2025, the Regional MDS Coordinator educated the facility [US FOIA (b)] on the requirement to complete and transmit the MDS according to Centers for Medicare and Medicaid Services (CMS) standards. The Regional MDS Coordinator will be	

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F 640	Continued From page 27	F 640	auditing 5 MDS discharge assessments monthly for 2 months to ensure timely completion and transmission of discharge assessments. 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. The Administrator/designee will review the results of the audits monthly. The results of the audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		4/18/25

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F 655	Continued From page 28 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Repeat Deficiency Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to develop and implement a baseline individual comprehensive care plan (ICCP) to meet resident preferences and goals to address all medical and psychosocial needs within 48 hours of admission. This deficient practice was identified for 1 of 27	F 655	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 #13's baseline care plan was updated on [redacted] to include an	

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F 655	Continued From page 29 residents (Resident #131) reviewed for ICCP and was evidenced by the following: On 2/28/25 at 9:38 AM, the surveyor observed Resident #131 being escorted off the unit. When asked, the US FOIA (b)(6)) stated that the resident was NJ Exec Order 26.4b and they wanted to provide the resident with activities. On 2/28/25 at 11:00 AM, the surveyor reviewed the Admission Record (an admission summary) which reflected Resident #131 had diagnoses which included but were not limited to; NJ Exec Order 26 A review of the most recent annual Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1, included but was not limited to; a Brief Interview for Mental Status (BIMS) of NJ Exe out of 15 which indicated a NJ Exec Order 26.4b1 . The MDS further documented that Resident #131 was administered NJ Exec Order 26.4b1 medications. The MDS revealed Resident #131 had care areas which included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 use. A review of the most recent NJ Exec Order 26.4b1 evaluation dated NJ Exec Order 26, included but was not limited to; the use of NJ Exec Order 26.4b1 at bedtime. The evaluation revealed a NJ Exec Order 26.4 was not recommended, included potential side effects, and recommended NJ Exec Order 26.4b1 for monitoring. A review of the ICCP failed to document a focus area for the use of an NJ Exec Order 26.4b1 medication, and medication for NJ Exec Order 26.4b1 goals associated with the medications; or any interventions.	F 655	individualized and comprehensive focus, goals and interventions related to the use of an NJ Exec Order 26.4b1 medication and medication for NJ Exec Order 26.4b1 ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be 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 would not recur. The Administrator educated the Interdisciplinary Care Plan team on the facility Baseline Care Plan policy on 03/19/2025. The Assistant Director of Nursing/designee will conduct an audit of 5 (five) new admissions weekly x 5 weeks to ensure that a baseline individualized comprehensive care plan (ICCP) related to the use of an antipsychotic medication and medication for dementia is developed within 48 hours of admission. 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	

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F 655	Continued From page 30 On 3/06/25 at 9:04 AM, the direct care Certified Nurse Aide (CNA) #1 stated she was familiar with Resident #131. CNA #1 stated in the resident's mind, the resident wanted NJ Exec Order 26.4b1, NJ Exec Order 26.4b [redacted], and perform normal daily tasks. CNA #1 stated the staff can sometimes provide clothes for the resident NJ Exec Order 26.4b1 [redacted] On 3/06/25 at 10:33 AM, the US FOIA (b)(6) [redacted] stated the process for developing a care plan would include when a resident was admitted, the supervisor on duty would be responsible to document a baseline care plan within 48 hours. The US FOIA (b) further stated that she expected NJ Exec Order 26.4b1 medications to be included in the baseline care plan. The US FOIA (b) was then made aware of the missing information in the baseline care plan. On 3/7/25 at 11:00 AM, the survey team met with the US FOIA (b)(6) [redacted]. The facility acknowledged that Resident #131's use of NJ Exec Order 26.4b1 medication use was not included in the baseline care plan. A review of the facility provided policy, "Use of Psychotropic Drugs" revised 9/2022, included but was not limited to; the use of psychotropic medication needed to be documented, monitored, and documented response to the medication. The indications for use will be documented ... Residents who use psychotropic medications shall receive non-pharmacological interventions ...	F 655	effectiveness of the systemic change. The Director of Nursing/designee will review the audit results weekly to determine if a baseline ICCP is developed and implemented within 48 hours of admission. The results of these observations will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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F 655	Continued From page 31 A review of the facility provided policy, "Baseline Care Plan" revised 7/2023, included but was not limited to; ... develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care ... that meet standards of quality care. The baseline care plan will be developed within 48 hours of the resident's admission and include the minimum information necessary to care for the resident including but not limited to ... initial goals ... physician orders. The facility must provide ... a summary of the baseline care plan that includes but not limited to; initial goals, summary of the medication instructions, services and treatments to be administered, and updated information as necessary. NJAC 8:39-11.2(d)(g)	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		4/18/25

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 _____	C 03/10/2025

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

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F 656	Continued From page 32 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to develop and implement an individual comprehensive care plan (ICCP) for a resident who received [redacted] and had an [redacted]. The deficient practice was identified for 1 of 1 resident (Resident #38) reviewed for [redacted] and was evidenced by the following:	F 656	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. On 03/04/2025, the Unit Manager revised	

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F 656	Continued From page 33 On 2/27/25 at 10:11 AM, the surveyor observed Resident #38 sitting in a wheelchair in their room. The surveyor observed the resident's [NJ Exec Order 26.4b1] with a [NJ Exec Order 26.4b1] between the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. Resident #38 stated that they had received medication through an [NJ Exec Order 26.4b1]. " On 2/28/25 at 9:56 AM, the surveyor again observed the [NJ Exec Order 26.4b1] inserted in Resident #38's [NJ Exec Order 26.4b1]. On 2/28/25 at 12:00 PM, the surveyor reviewed the electronic medical record (EMR). A review of the Admission Record (an admission summary) revealed Resident #38 had diagnoses which included, but were not limited to; [NJ Exec Order 26.4b1]. A review of the admission Minimum Data Set (MDS) an assessment tool dated [NJ Exec Order 26.4b1], included a Brief Interview for Mental Status (BIMS) of [NJ Exec Order 26.4b1] out of 15 which indicated [NJ Exec Order 26.4b1]. A review of the Order Summary Report documented a physician order dated [NJ Exec Order 26.4b1] for [NJ Exec Order 26.4b1] per hour [NJ Exec Order 26.4b1] every shift for [NJ Exec Order 26.4b1] for 3 days with an end date of [NJ Exec Order 26.4b1]. A review of the ICCP dated [NJ Exec Order 26.4b1], including all resolved and canceled focus areas, failed to document the insertion and use of [NJ Exec Order 26.4b1] including a focus area, goals, or interventions. On 3/4/25 at 9:00 AM, the [US FOIA (b)(6)] reviewed the EMR and acknowledged there was no ICCP for the use of [NJ Exec Order 26.4b1] On 3/04/25 at 9:52 AM, the [US FOIA (b)(6)] stated that [NJ Exec Order 26.4b1] should "be in the	F 656	Resident #38's care plan to include a focus area, goals and interventions related to the [NJ Exec Order 26.4b] and use of [NJ Exec Order 26.4b1]. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents on intravenous therapy have the potential to be 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 would not recur. On 03/19/2025, the Administrator provided education to all members of the Interdisciplinary Care Plan team on the facility's Comprehensive Care Plan policy. The Assistant Director of Nursing/designee will conduct an audit of 5 (five) residents weekly x 5 weeks to ensure that an ICCP is developed and implemented related to the insertion and use of intravenous therapy. 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.	

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F 656	Continued From page 34 care plan" and when no longer in use, it would be marked as resolved. The [redacted] further stated, "I am educating the staff". A review of the facility provided policy, "Comprehensive Care Plans" revised 6/2023, included but was not limited to; to develop and implement a comprehensive person-centered care plan consistent with resident rights, includes measurable objectives and time frames to meet medical, nursing, and mental and psychosocial needs. The process will include an assessment of the resident's strengths and needs ... The care plan will describe at a minimum ... services to be furnished to attain or maintain the highest practicable physical well-being; any specialized services; specific interventions that reflect the needs and preferences of the resident; will include measurable objectives and timeframes ... and interventions; and the staff responsible for carrying out interventions and the staff will be made aware when changes are made. NJAC 8:39-11.2(e)(i)	F 656	The Director of Nursing/designee will review the results of the audit monthly. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint NJ # 169842 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide	F 677	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	4/18/25

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F 677	Continued From page 35 appropriate NJ Exec Order 26.4b1 care and NJ Exec Order 26 for 2 of 2 residents (Resident #73 and #104) reviewed for activities of daily living. This deficient practice was evidenced by the following: On 02/27/25 at 9:57 AM, the surveyor observed Resident #73 in bed. A US FOIA (b)(6) was at the bedside providing care and an interview conducted with the US FOIA (b) revealed that the resident NJ Exec O was intact. Per the surveyor request the US FOIA (b) checked the resident for NJ Exec Order 26.4b1 care. The surveyor observed that Resident #73 was wearing NJ Exec Order 26.4b1 NJ Ex Order 26 One of the NJ Exec O was folded and placed inside the first NJ Exec O and secured in place with the liner of the first NJ Exec Ord The US FOIA (b) informed the surveyor that the second NJ Exec O was to catch the NJ Exec Ord while the resident was in bed. On 2/27/25 at 10:30 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #73. The Admission Record revealed with diagnoses that included, but were not limited to; NJ Exec Order 26.4b1 . The Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4b1 , reflected that Resident #73 was NJ Exec Order 26.4b1 and required extensive assistance with Activities of Daily Living (ADL). Resident #73 scored NJ Exe out of 15 on the Brief Interview for Mental Status (BIMS) which indicated a NJ Exec Order 26.4b1 . A review of Resident # 73's Care Plan (CP), with no revision date indicated that Resident #73 had NJ Exec Order 26.4b1 . Resident #73 was NJ Exec Order 26.4b1	F 677	in the CMS 2567, Statement of Deficiencies. On 2/27/2025, NJ Exec Order 26.4b1 care was immediately rendered by the staff for Resident #73 and Resident #104. On 3/5/2025, staff offered Resident #104 shower however NJ Exe NJ Exec Order 26 to have one at that time. On 3/7/2025, the Director of Nursing reviewed the NJ Exec Order 26.4b1 care and bathing/shower schedules for Resident #73 and Resident #104. Staff were re-educated on the NJ Exec Order 26.4b1 care and shower policies in the facility on 3/5/2025. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents requiring assistance with incontinence care and bathing have the potential to be 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 would not recur. The Assistant Director of Nursing/designee provided education to	

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F 677	Continued From page 36 NJ Exec Order 26.4b1 of NJ Exec Order 26.4 and NJ Exec Order 26.4b1 functions and at risk for NJ Exec Order 26.4b1. The CP interventions included but were not limited to: Provide NJ Exec Order 26.4b1 care every shift, NJ Exec O and NJ Exec Order 26.4b1 every 2 hours. On 03/05/25 at 10:50 AM, the surveyor interviewed Resident #73 with an activity staff that was able to NJ Exec Order 26.4b1 for the resident. Upon inquiry, Resident #73 stated they received a NJ Exec O daily, and had not had a NJ Exec Order 26 for 4 months. Resident #73 stated that they would like to get out of the bed for NJ Exec Order 26.4b The activity staff informed the US FOIA (b)(6) of the interview with the resident. On 03/05/25 at 10:30 AM, the US FO informed the surveyor that the facility had a NJ Exec Order 26.4b1) on the NJ Exec floor that could be used to NJ Exec Order 26.4 Resident #73 to the shower room. The surveyor went to the NJ Exec floor with the US FO and observed a NJ Exec Order 26. that did not appear to accommodate a NJ Exec Order 26.4b1 out of the bed. The facility US FO confirmed they had not used the NJ Exec Order 26. before for a NJ Exec Order 26.4b The facility then confirmed that Resident #73 only received a NJ Exec Order 26.4b1 daily, and could not verify when the resident last had a NJ Exec Order 26.4b The resident's CP did not indicate that staff would get the NJ Exec Order 26. on the NJ Exec floor to shower the resident on the day assigned for shower. A review of the shower log with the US FOIA) revealed 30 of the log dates for NJ Exec Order 26.4b1 for the NJ Exec floor, were left blank and the US FOIA could not indicate if the resident was NJ Ex Order 26.4(b) On 3/6/25 at 9:30 AM, during an interview with the US FOIA (b who cared for Resident #73, she stated that she washed the resident in bed every day,	F 677	all Certified Nurse Aides on 03/17/2025 related to facility policy on providing Activities of Daily Living (ADLs) to residents. The Assistant Director of Nursing/designee will conduct an audit for 10 (ten) residents requiring assistance with bathing and incontinence care daily x 1 weeks then 5 (five) residents weekly x 4 weeks. 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. The Director of Nursing/designee will review the audit results weekly to determine if facility staff are providing time assistance with ADLs for residents requiring the same. The results of these observations will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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F 677	Continued From page 37	F 677		

and was not informed to get the [redacted] from the [redacted] floor to transfer the resident for a [redacted]

2. On 2/27/25 at 10:01 AM during the initial tour, the surveyor observed Resident #104 was in bed. The Resident informed the surveyor that they were last provided with [redacted] care at 6:00 AM that morning and would next get [redacted] after lunch around 12:00 PM. The surveyor then asked the resident if they were [redacted] and the resident stated, "yes". The surveyor left the room and observed a [redacted] in the hallway. The surveyor asked the [redacted] to assist with an observation. At 10:35 AM the [redacted] entered Resident's #104's room with the surveyor to perform an [redacted] observation. The resident was observed wearing an [redacted] that was [redacted] with [redacted] and was [redacted] with [redacted]

On 2/27/25 at 11:30 AM the surveyor reviewed the EMR for Resident #104. The Admission Record revealed the resident was admitted to the facility with diagnoses which included, but were not limited to; [redacted]. The Quarterly MDS dated [redacted] revealed that Resident #104 had [redacted]. The MDS also revealed that Resident #104 was always [redacted]

On 02/28/25 at 11:12 AM, the surveyor interviewed the nurse regarding [redacted] care. The nurse stated that she was not aware of a policy that would dictate when [redacted] care was to to be provided. The nurse went on to state that the residents were provided with [redacted] care before breakfast and again after lunch.

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F 677	Continued From page 38 On 03/04/25 at 10:59 AM, the surveyor observed a [US FOIA (b)] about to exit Resident #104's room. The surveyor asked the [US FOIA (b)] to assist with an [NJ Ex Order 26.4(b)(1)] observation. The resident was observed [NJ Exec Order] with [NJ Exec Ord] and [NJ Exec Order] An interview with the [US FOIA (b)] at 11:05 AM, revealed that she provided care to the resident this morning, and would again [NJ Exec Order 26] the resident after lunch. The above concerns were discussed with the [US FOIA (b)(6)] and the US FOIA (b)(6) on [NJ Exec Order] at 1:30 PM. On 3/7/25 at 11:17 AM, the survey team met with the US FOIA (b)(6) and the above concerns were mentioned. The [US FOIA (b)] stated, "that was unacceptable" regarding the rolled up NJ Exec Order 26.4b1 inside of the NJ Exec Order 26.4b1, and stated that there should be no residents wearing NJ Exec Order 26.4b1 . Upon reviewing the concerns regarding residents not receiving [NJ Ex Order 26.4(b)(1)] the [US FOIA (b)(6)] stated, "I know there were holes you found" regarding the [NJ Exec Order 26.] documentation. A review of the facility's policy titled, "Activities of Daily Living"," revised on 7/2023, indicated under Policy: "The facility must provide necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such deterioration was unavoidable. The same policy under "Procedure:	F 677		

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F 677	Continued From page 39 "3.. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming personal and oral hygiene. NJAC 8:39-27.1(a)2(h)	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility provided documents, it was determined that the facility failed to care for, and remove an NJ Exec Order 26.4b1 for 1 of 1 resident (Resident #38) reviewed for NJ Exec Order 26.4b1. This deficient practice was evidenced by the following: On 2/27/25 at 10:11 AM, the surveyor observed Resident #38 in their room with an NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 between the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Resident #38 stated that the NJ Exec Order 26.4b1 had been NJ Exec Order 26.4b1 weeks ago for medication and had never been removed. On 2/28/25 at 9:56 AM, the surveyor observed Resident #38 in their room with the NJ Exec Order 26.4b1 line still in place.	F 684	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. On NJ Exec Order 26.4b1, Resident #38's NJ Exec Order 26.4b1 was discontinued. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with intravenous (IV) line have the potential to be affected by the	4/18/25

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F 684	Continued From page 40 On 3/04/25 at 9:00 AM, the US FOIA (b)(6) stated the NJ Exec Order 2 was NJ Exec Order 26.4b because the resident had been receiving an NJ Exec Order 26.4b1 which had been stopped on NJ Exec Order 26.4. The US FOIA (b)(6) and surveyor reviewed the electronic medical record (emr) and the US FOIA (b) was unable to locate any orders for the NJ Ex The surveyor inquired about the orders for the care of the line and the NJ Ex Order 26.4(b)(1). The US FOIA (b)(6) reviewed the emr and was unable to locate any orders to maintain the NJ Exec Order 26.4b of the NJ Exec Order 2 or to care for the NJ Ex Order 26.4(b)(1) over the NJ Exec Order 26.4b NJ Exec O or any documentation that the NJ Ex was being NJ Exec Order 26 to maintain NJ Exec Order 26.4b or the dressing was being changed by the nursing staff. The US FOIA (b)(6) stated there should be a physician's order for both. The US FOIA (b)(6) further stated she took the verbal orders from the US FOIA (b)(6) but was unable to locate the orders. She stated she was waiting for the orders to remove the NJ Exec Order 2, but the NJ Ex had been removed. The US FOIA (b)(6) and surveyor went to the resident's room. Resident #38 did not have the NJ Exec Order 2 and informed the surveyor and US FOIA (b)(6) that "it was just removed". On 3/4/25 at 10:00 AM, the surveyor reviewed the emr. A review of the Admission Record (an admission summary) included a diagnosis of NJ Exec Order 26.4b1. A review of the admission Minimum Data Set (MDS) an assessment tool dated NJ Exec Order 2, included a Brief Interview for Mental Status (BIMS) of NJ Ex out of 15 which indicated NJ Exec Orde A review of the Order Summary Report (OSR) revealed the following physician orders: dated NJ Exec Order 2, NJ Exec Order 26.4b1 one time only for NJ Exec Order 26.4b1 dated NJ Exec Order 26.4 NJ Exec Order 26.4b1	F 684	deficient practice. ELEMENT 3 What measures will be put into place or systemic changes will be made to ensure that the deficient practice would not recur. The Assistant Director of Nursing/designee provided education to all licensed nurses on 03/17/2025 related to IV therapy policy and Physician's Order Policy. The Assistant Director of Nursing/designee will conduct audit for 5 (five) residents with IV site daily x 1 weeks then 5 (five) residents weekly x 4 weeks. 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. The Director of Nursing/designee will review the audit results weekly to determine if facility staff are providing care for residents with IV access. The results of these observations will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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NJ Exec Order 26.4b1 every shift for 3 days; and dated NJ Exec Order 26.4b with an end date of NJ Exec Order 26.4b, NJ Exec Order 26.4b1 every shift for 3 days. A review of a nursing note (nn) dated NJ Exec Order 26.4, documented the resident was on NJ Exec Order 26.4b1 until NJ Exec Order 26.4. The next nn dated NJ Exec Order 26.4, documented NJ Exec Order 26.4b1, but failed to document any care or orders for the NJ Exec Order 2. A review of the Individual Comprehensive Care Plan (ICCP) including resolved and canceled focus areas date initiated NJ Exec Order 2, failed to include any focus area, goals, or interventions for the care and use of NJ Exec Order 26.4b1.

On 3/04/25 at 9:16 AM, the US FOIA (b)(6) stated if a resident completed NJ Exec Order 26.4b1 the NJ Ex should be removed. She further stated that if the NJ Ex was not being removed, it needed to be NJ Exec Order 26.4b1) and that the orders and documentation that this was done should be documented in the treatment administration record (TAR).

At 9:52 AM, the US FOIA (b) informed the surveyor that she had looked into this concern. She stated Resident #38 had 3 days of NJ Exec Order 26.4b1 that had been a verbal order. The US FOIA (b) added that the staff should have entered the orders in the emr to include a start date and end date and should be documented in the TAR.

On 3/04/25 at 10:33 AM, during a telephone interview the NP stated she gave a verbal order to the US FOIA (b)(6) to administer the NJ Exec Order 26.4b1 for 3 days and to discontinue the NJ Ex after the order was completed. She was not sure the exact date the NJ Ex was to be removed.

On 3/05/25 at 9:24 AM, the US FOIA (b)(6)

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

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F 684	Continued From page 42	F 684		

US FOIA (b)(6) stated a resident with an [NJ Exec Order 26.4b1] would need to have monitoring every shift, change the [NJ Exec Order 26.4b1] dressing once a week, and to [NJ Exec Order 26.4b1]. She further stated she was familiar with Resident #38 who had a [NJ Exec Order 26.4b1] but no [NJ Exec Order 26.4b1] upon admission. The US FOIA (b)(6) stated that she would focus on NJ Exec Order 26.4b1 use and not for [NJ Exec Order 26.4b1] She stated that when a resident was finished with the [NJ Exec Order 26.4b1], the [NJ Exec Order 26.4b1] should be discontinued because it was a source of NJ Exec Order 26.4b1.

A review of the facility policy, "Intravenous Therapy" revised 7/2023, included but was not limited to; IV tubing is changed every 96 hours or soon if the integrity of the system is compromised; all IV tubing is to be labeled with the date, time and initials; IV sites are checked ever 4 hours for signs and symptoms of infection and inflammation; IV documentation is recorded in the nurses' notes and/or medication administration record (MAR); and if the catheter is not being used for IV fluids or medications ... will discontinue per the Practioner orders.

A review of the facility policy, "Physician Orders Policy" revised 5/2023, included but was not limited to; ... ensure that each resident receives necessary care and services while in the facility. The physician orders should be transcribed and/or entered in the electronic medical record of the resident. A licensed nurse or professional shall provide the care and services based on a physician order when indicated.

A review of the facility policy, "Documentation, Resident Record" revised 7/2023, included but was not limited to; all services ... shall be documented in the resident's medical record. All

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F 684	Continued From page 43 ... medications administered; services performed must be documented in the resident's clinical record. CNAs make entries in a point of care on the care hey provided on their shift, including any refusals or unusual occurrences which must be reported to the nurse assigned. A review of the facility provided position title, "Certified Nurse Aide" undated, included but was not limited to; performs duties in accordance with recognized standards; provides maximum resident care services; positions residents in correct body alignment ... ; ensures that residents receive the highest quality of services; and assists with treatments. A review of the facility provided position title, "Licensed Practical Nurse" undated, included but was not limited to; takes an active role in resident assessment and care; administers medication and/or treatment and documentation of the same for the residents; responsible for clinical documentation; assists in developing and implementing care plans; communicates pertinent data to the charge nurse and/or physician; provides for the physical comfort and safety of the residents; supervises nursing personnel in providing direct resident care; and ensures that residents receive the highest quality of service. A review of the facility provided position title, "Registered Nurse" undated, included but was not limited to; under the supervision of the DON, utilizes a general understanding of the principles of nursing and basic physical assessment skills in the development of and implementation of care plans to ensure resident needs are met; formulates individualized nursing care plans; assesses residents daily and implements a	F 684		

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F 684	Continued From page 44 change in action as needed; communicates resident information; maintains accurate resident care record and documents pertinent data; dispenses medication and performs treatments in accordance with policies and procedures; and ensures residents receive the highest quality of services. A review of the facility provided position title, "Unit Manager" undated, included but was not limited to; twenty-four hour responsibility for the continuity of nursing care and the management of the resident welfare; assesses the performance of nursing personnel as it relates to the standards of care and goals of the individual; encourages nursing staff to perform their jobs to the fullest of their potential; demonstrates, teaches and evaluates nursing skills utilized; concerns themselves with the safety of all facility residents; and ensures that residents receive the highest quality of service. A review of the facility provided position title, "Director of Nursing" undated, included but was not limited to; evaluates work performance of all nursing personnel; performs rounds to observe residents and ensure needs are being met; and conducts observations of nursing care to ensure nursing staff is current in their knowledge and skills. On 3/6/25 at 12:53 PM, the above concern was presented to the facility administration team. The facility had no additional information to provide. NJAC 8:39-27.1(a)	F 684		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		4/18/25

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F 688	Continued From page 45 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to consistently perform and document NJ Exec Order 26.4b1 for 1 of 2 residents (Resident #51) reviewed for NJ Exec Order 26.4b1 care. This deficient practice was evidenced by the following: On 2/27/25 at 10:17 AM, the surveyor observed Resident #51 in bed and their NJ Exec Order 26.4b and NJ Exec Orde were NJ Exec Order 26.4b1. On 2/27/25 at 1:23 PM, the surveyor reviewed the electronic medical record. The Admission Record revealed diagnoses which included need for assistance with NJ Ex Order 26.4(b)(1). A review of the quarterly MDS dated NJ Exec Order 2, documented a BIMS of NJ Ex out of 15 indicating NJ Exec Order 26.4b1	F 688	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. On NJ Exec Order 26.4b1, Resident #51 was assessed by the US FOIA (b)(6) for NJ Exec Order 26.4b1 . On NJ Exec Order 26.4b1 Resident #51 continues to daily NJ Exec Order 26.4b1	

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F 688	Continued From page 46 NJ Exec Order 26.4b1 and that Resident #51 had ended both NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 on NJ Exec Order 2. A review of the Order Summary Report revealed an order dated NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 for daily NJ Exec Order 26.4b1) on NJ Exec Order 26.4b1) and NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 to all NJ Exec Order 26.4b1. A review of the ICCP included a focus area dated NJ Exec Order 2 at risk for NJ Exec Order 26.4b1 to be implemented; a goal to participate in NJ Exec Or to NJ Exec Order 26.4b1 ; and interventions which included NJ Exec Or for NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 to all NJ Exec Order 26.4b1. On 2/28/25 at 10:02 AM, a Registered Nurse (RN) #5 stated Resident #51 would NJ Exec Order 26.4b1 provided by the NJ Exec Order 26.4b1 department on the NJ Exec Order 26.4b1 from 2 PM to 4 PM. On 2/28/25 at 11:23 AM, the US FOIA (b)(6) reviewed Resident #51's emr and stated the resident was not on NJ Exec Order 26.4b but had been given orders for the nursing staff to perform the NJ Exec Order 26.4b and NJ Exec Order 26.4b and stated the documentation should be in the emr. On 2/28/25 at 11:29 AM, during a second interview, RN #5 reviewed the emr. She stated that the NJ Ex Order 26.4(b)(1) care order would be administered by the US FOIA (b)(6) However, she was unable to access the documentation of the NJ Exec Or being completed. On 2/28/25 at 11:35 AM, the US FOIA (b)(6)	F 688	NJ Exec Order to all NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Program performance is documented by the staff consistently. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents on functional maintenance program have the potential to be 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 would not recur. On 3/20/2025, the Assistant Director of Nursing/designee provided education to all licensed Certified Nurse Aides on the performance of and documentation of functional maintenance activities. The Assistant Director of Nursing/designee provided education to all licensed nurses on 3/20/2025 related to Physician's Order policy. The Assistant Director of Nursing/designee provided education to all licensed staff on 03/20/2025 related to Resident Record Documentation. The Assistant Director of Nursing/designee will conduct audit for 10 (ten) residents enrolled in a Functional Maintenance program daily x 1 week then	

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F 688	Continued From page 47 US FOIA (b)(6)) was unable to find any consistent documentation for the NJ Exec Ord being administered to Resident #51. She stated she was responsible to ensure the NJ Exec Ord was being completed and that it was important for the NJ Exec Ord to be completed so the resident would not be so NJ Exec O The US FOIA (b)(6) stated she "would usually check for documentation at the end of the shift but has not been checking." On 2/28/25 at 11:51 AM, the US FOIA (b) stated that when NJ Exec Order 26.4 ordered NJ Ex Order 26.4(b)(1) care it would be completed by the CNAs and the nurses should know about the order. She stated it would either be documented in a binder located on the Unit or in the emr. The US FOIA (b) stated the facility policy would allow for documentation in either area. On 2/28/25 at 12:25 PM, the US FOIA (b) returned and provided the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 documentation with multiple missing dates of documentation. The US FOIA (b) provided the NJ Exec Order 26.4b and NJ Exec Order 26.4b1 documentation which revealed no documentation on the weekends. The US FOIA (b) acknowledged the missing documentation and stated that there should be no missing documentation as the order was for daily NJ Exec Order 26.4b and NJ Exec Order 26.4b1 The missing documentation was as follows: NJ Exec Order 26.4b1, 9 of 28 days missing and no documented amount of repetitions or sets. NJ Exec Order 26.4b1, 8 of 21 days missing and no documented amount of repetitions or sets. NJ Exec Order 26.4b1, 8 of 31 days missing and no documented amount of repetitions or sets. NJ Exec Order 26.4b1, 4 of 30 days missing and no documented amount of repetitions or sets. NJ Exec Order 26.4b1 3 of 31 days missing and no	F 688	5 (five) residents weekly x 4 weeks. 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. The Director of Nursing/designee will review the audit results weekly to determine if facility staff performing and documenting activities related to functional maintenance program. The results of these observations will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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F 688	Continued From page 48 documented amount of repetitions or sets. A review of the facility policy, "Physician Orders Policy" revised 5/2023, included but was not limited to; ... ensure that each resident receives necessary care and services while in the facility. The physician orders should be transcribed and/or entered in the electronic medical record of the resident. A licensed nurse or professional shall provide the care and services based on a physician order when indicated. A review of the facility policy, "Documentation, Resident Record" revised 7/2023, included but was not limited to; all services ... shall be documented in the resident's medical record. All ... medications administered; services performed must be documented in the resident's clinical record. CNAs make entries in a point of care on the care hey provided on their shift, including any refusals or unusual occurrences which must be reported to the nurse assigned. A review of the facility policy, "Physician Orders Policy" revised 5/2023, included but was not limited to; ... ensure that each resident receives necessary care and services while in the facility. The physician orders should be transcribed and/or entered in the electronic medical record of the resident. A licensed nurse or professional shall provide the care and services based on a physician order when indicated. A review of the facility policy, "Documentation, Resident Record" revised 7/2023, included but was not limited to; all services ... shall be documented in the resident's medical record. All ... medications administered; services performed must be documented in the resident's clinical	F 688		

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F 688	Continued From page 49	F 688		

record. CNAs make entries in a point of care on the care hey provided on their shift, including any refusals or unusual occurrences which must be reported to the nurse assigned.

A review of the facility provided position title, "Certified Nurse Aide" undated, included but was not limited to; performs duties in accordance with recognized standards; provides maximum resident care services; positions residents in correct body alignment ... ; ensures that residents receive the highest quality of services; and assists with treatments.

A review of the facility provided position title, "Unit Manager" undated, included but was not limited to; twenty-four hour responsibility for the continuity of nursing care and the management of the resident welfare; assesses the performance of nursing personnel as it relates to the standards of care and goals of the individual; encourages nursing staff to perform their jobs to the fullest of their potential; demonstrates, teaches and evaluates nursing skills utilized; concerns themselves with the safety of all facility residents; and ensures that residents receive the highest quality of service.

A review of the facility provided position title, "Director of Nursing" undated, included but was not limited to; evaluates work performance of all nursing personnel; performs rounds to observe residents and ensure needs are being met; and conducts observations of nursing care to ensure nursing staff is current in their knowledge and skills.

On 3/6/25 at 12:53 PM, the above concern was presented to the facility administration team. The

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F 688	Continued From page 50 facility had no additional information to provide. NJAC 8:39-27.1(a)	F 688		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure NJ Exec Order 26.4b1 were properly disposed of and ensure adequate supervision was provided to a resident who had a history of [redacted] This deficient practice was identified for 1 of 1 resident (Resident #1) observed during the medication pass and 1 of 1 resident reviewed for accidents (Resident #110). The evidence is as follows: a) On 3/4/25 at 8:39 AM, the surveyor conducted a medication pass observation and observed the US FOIA (b)(6)) prepared medication for Resident #1. The [redacted] prepared the following medications: NJ Exec Order 26.4b1 [redacted] 1 tablet (a medication used to treat [redacted] NJ Exec Order 26.4b1	F 689	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 #1 remains in the facility and continues to demonstrate occasional behavior of [redacted] of medications. The IDCP (Interdisciplinary Care team) agreed to reduce the number of medications administered; modified the care plan as to the timing of medication administration and/or offer to crush the medication when necessary. Liquid medication was tried but NJ Exec Order 26.4b1. Medications that the residents [redacted] to take are properly disposed.	4/18/25

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F 689	Continued From page 51 NJ Exec Order 26.4b1; NJ Exec Order 26.4b1) medication used to treat NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 1 tab medication (to treat NJ Exec Order 26.4b1); NJ Exec Order 26.4b1 1 tab medication used to treat NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 1 tab medication to treat NJ Exec Order 26.4b1; and NJ Exec Order 26.4b1 . On 3/4/25 at 9:03 AM, the resident NJ Exec Order 26.4 all of the medications and also NJ Exec Order 26.4b1 on the floor. The US FOIA (b) retrieved the NJ Exec Order 26.4b1 and then discarded all the medications, which included the US FOIA (b)(6) into the trash can attached to the medication cart. The nurse left the medication cart in the hallway next to the resident's room, and went to the nurse's station to call the physician. The surveyor remained in the hallway next to the medication cart. On 3/4/25 at 9:08 AM, a housekeeping staff approached the medication cart and removed the plastic bag which contained the discarded medications and placed the garbage bag in their trash basket. The surveyor approached the housekeeper and informed her not to dispose of the bag, and the staff could not understand and insisted on holding the bag. The surveyor then summoned the US FOIA (b)(6) who was in the hallway. The surveyor explained the above concern to the US FOIA (b)(6) and the US FOIA (b)(6) then removed the bag that contained the discarded medications from the housekeeping trash basket. The US FOIA (b)(6) opened the bag and was able to visualize the medications in the plastic bag. The US FOIA (b)(6) then gave the plastic bag to the US FOIA (b)(6)). The US FOIA (b)(6) informed the surveyor that all medications should be	F 689	Resident # 110 remains a resident at the facility and continues to attend the NJ Exec Or The resident remains at risk for NJ Exec Interventions to prevent NJ Exec will continue including NJ Exec Order 26.4b1 when in the day room and/or on the unit. The resident's last recorded NJ Exec was on NJ Exec Order 26.4b1 ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who receive medications and demonstrate a behavior of refusal of medication administration has the potential to be affected by this deficient practice. All residents that are identified as having a high risk for fall have the potential to be affected by this deficient practice. ELEMENT 3 What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All nurses were given an in-service by the DON/designee about proper disposal of all controlled substances. Competency and return demonstration of understanding of the teaching was obtained. All staff were given in-service about residents identified as a high risk for fall and care planned interventions that needed to be followed. Competency and	

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F 689	Continued From page 52 discarded in the drug buster (container to safely dispose of medication) located inside of each medication cart, and stated, "NJ Exec Order 26.4b1 should be witnessed and discarded with two licensed staff." The US FOIA (b)(6) then opened the medication cart and there was no drug buster inside of the medication cart. On 3/4/25 at 9:15 AM, the surveyor interviewed the US FOIA (b who disposed of the medication into the trash can. The US FOIA (b informed the surveyor that she failed to dispose of the medications properly. On 3/4/25 at 9:50 AM, the US FO approached the surveyor and showed the medications that she retrieved from the plastic bag, and the US FO informed the surveyor that the nurse was educated on proper drug disposal. b. On 3/4/25 at 10:51 AM, the surveyor observed Resident #110 in the dayroom in a NJ Exec Order 26 chair. The resident was sleeping in the chair and there were ten other residents observed in the room. On 3/5/25 at 8:55 AM, the surveyor observed Resident #110 in the dayroom on the NJ Exec floor. The resident had their NJ Exec Order 26.4b1 and was sleeping. The activity staff in attendance was not in direct observation of the resident as she had her back turned and was preparing a drink for another resident. The surveyor asked the staff if she was alone. The Staff stated that the other activity staff went to the floor to transfer other residents. At that time, the surveyor requested any incident reports for Resident #110 from the facility. On 03/05/25 at 10:30 AM, the surveyor reviewed the facility provided Incident Reports which	F 689	return demonstration of understanding of the teaching was obtained. 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. A random audit will be conducted by the DON/designee 3x weekly for the next 3 months on how controlled substances are disposed of. A random audit will be conducted by the DON/designee 3x weekly for the next 3 months on residents that are identified as high risk for fall and require supervision and all interventions are followed.	

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	315344	A. BUILDING _____ B. WING _____	C 03/10/2025

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F 689	Continued From page 53 revealed: An Incident Report dated [redacted] timed 6:30 AM, the Report reflected that staff informed the [redacted] that Resident #110 was found on the floor in the dayroom at 6:30 AM. The staff indicated that she had to briefly leave the dayroom to attend to another resident. Resident #110 [redacted]. The [redacted] did not inform the [redacted] that the resident was [redacted] in the room. Intervention added, reeducate staff not to leave the resident [redacted] Provide Resident #110 with a wheelchair [redacted] to promote safety. Another [redacted] occurred on [redacted] at 1:55 PM, in the activity room. According to the Incident Report, the activity staff turned their back to attend to another resident, Resident #110 [redacted]. The intervention was to place Resident #110 in an area near the staff who are conducting the activities. On 8/8/23 at 5:35 AM the resident fell in the dayroom. The statement provided revealed that the Resident was [redacted] at 5:25 AM. The [redacted] brought the resident to the dayroom and left the resident [redacted] The resident [redacted] and [redacted] at 5:35 AM. The resident [redacted] to the [redacted] which measured [redacted] On 3/5/25 at 12:00 PM, the surveyor reviewed the residents medical record which revealed: The Admission Face Sheet reflected that Resident #110 was admitted to the facility with diagnoses which included, but were not limited to; [redacted]	F 689		

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NJ Exec Order 26.4b1 The Minimum Data Set (MDS) dated NJ Exec Order 26.4b1 reflected that Resident #110 had NJ Exec Order 26.4b1 .
The resident undated comprehensive care plan provided by the facility on NJ Exec Order 26 at 11:30 AM, reflected that Resident #110 was at NJ Exec Order 26.4b for NJ Exec O related to history of NJ Exec Order 26.4b1 of both NJ Exec Order and NJ Exec Order 26.4b1 The interventions on the care plan were to keep needed items within reach, place in supervised areas (dayroom/near nurses station) keep the NJ Exec Order 26.4b1 on the side.

On 3/6/25 the surveyor discussed the above concerns with the US FOIA (b)(6) and asked to provide any additional information regarding the NJ Exec Or

On 3/7/25 at 11:30 AM the US FOIA (b)(6) informed the survey team that Resident #110 should not be NJ Exec Order 26.4b1 in the dayroom and the staff had been educated. No additional information was provided.

The policy for discarding and destroying medications last revised 03/2018, indicated the following: Medications that cannot be returned to the dispensing pharmacy (e.g., non-unit dose medications, medications refused by the resident, and /or medications left by residents upon discharge) will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances.

The policy for incidents/accidents revealed the

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F 689	Continued From page 55 following: A review of the facility's policy titled, " Fall Prevention Program" last revised 4/2023 revealed the following: Policy Each resident will be assessed for the risks of falling and will receive care and services in accordance with the level of risk to minimize the likelihood of falls. Procedure 1. The facility utilizes a standardized risk evaluation tool for determining a resident's fall risk. 3. Interventions will address resident's risk factors as identified by the risk assessment tool. Falls interventions will be documented on the resident's medical records e.g., baseline care plan. NJAC 8:39-294(i); 27.1(a)	F 689		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		4/18/25

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F 690	Continued From page 56 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to record and document the NJ Exec Order 26.4b1 for residents with an NJ Exec Order 26.4b1 per the Physician Order. This deficient practice was identified for 1 of 2 resident's reviewed for NJ Exec Order 26 (Resident #122) and was evidenced by the following: On 3/4/25 at 9:48 AM, the surveyor observed Resident #122 resting in their bed. The resident's NJ Exec Order 26.4b1 was in a NJ Exec Order 26.4b1 and secured to the bed frame on the NJ Exec Order 26.4b1. On 3/4/25 at 10:38 AM, the surveyor reviewed the electronic medical record for Resident #122 which revealed the following: The resident was admitted to the facility with diagnoses that	F 690	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. On 3/4/2025, Resident #122 was assessed by the Registered Nurse/Unit Manager for the clinical necessity of using the NJ Ex Order 26.4(b)(1). ELEMENT #2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents with indwelling catheter have	

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F 690	Continued From page 57 included but were not limited to, NJ Exec Order 26.4b1 [redacted] A review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15 indicative of NJ Exec Order 26.4b1. Further review of the MDS reflected that Resident #122 had an NJ Exec Order 26.4b1 [redacted]). Resident #122 was NJ Exec Order 26.4b1 on staff for NJ Exec Order 26.4 and NJ Exec Order 26.4b1. A review of the Comprehensive Care plan CP) included a focus area dated NJ Exec Order 26.4 which indicated that Resident #122 had an NJ Exec Order 26.4b1 related to: NJ Exec Order 26.4b1 [redacted]) with NJ Exec Order 26.4b1 status post NJ Ex Order 26.4(b)(1) A review of the Physician Order Summary, (POS) revealed an order dated NJ Exec Order 26., to NJ Exec Order 26.4b1 and record NJ Exec Orc output every shift. The corresponding PO was transcribed into the electronic Treatment Administration Record (eTAR). Further review of the NJ Exec Order 26.4b1 [redacted] eTARs for Resident #122 revealed the following date and time where the NJ Exec Order 26.4b1 was not recorded: Date: Shifts with NJ Exec Order 26.4b NJ Ex Order 26 documented: NJ Exec Order 26.4 Day shift (7 AM - 3 PM)	F 690	the potential to be 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 would not recur. On March 19, 2025, the Assistant Director of Nursing/designee provided education to all licensed Certified Nurse Aides and licensed nurses on the process of recording and documenting the urinary output for residents with indwelling catheter. The Assistant Director of Nursing/designee will conduct audit for 3 (three) residents with indwelling catheter, to ensure that urine output is recorded, daily x 1 week then 3 (three) residents weekly x 4 weeks. 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. The Director of Nursing/designee will review the audit results weekly to determine if facility staff performing and documenting activities related to functional maintenance program. The results of these observations will be reported to the facility's quarterly Quality	

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Continued From page 58

NJ Exec Order 26.4 Evening shift (3 PM -11 PM)
NJ Exec Order 2 Day shift (7 AM -3 PM)
NJ Exec Order 2 Day shift (7 AM -3 PM)
NJ Exec Order 2 Day shift (7 AM -3 PM)
NJ Exec Order 26.4 Day shift (7 AM -3 PM)
NJ Exec Order 26.4 Day shift (7 AM - 3 PM)
NJ Exec Order 26.4 Evening shift (3 PM - 11 PM)
NJ Exec Order 26.4 Day shift (7 AM - 3 PM)
NJ Exec Order 26.4 Evening shift (3 PM - 11 PM)
NJ Exec Order 2 Night shift (11 PM - 7 AM)
NJ Exec Order 2 Evening shift (3 PM-11 PM)

On 3/5/25 at 9:11 AM, during an interview with the surveyor, the Certified Nurse Aide (CNA #1) stated if she emptied the NJ Exec Order 26.4b1, she would measure the NJ Exec Order 26.4b1 and reported the amount to the nurse. She would also inform the nurse of any change in the NJ Exec Order 26.4b1.

On 3/5/25 at 9:17 AM, during an interview with the surveyor, the US FOIA (b)(6) stated she would check the resident's NJ Exec Order 26.4b1 bag at the beginning and at the end of her shift and NJ Exec Order 26.4b1. The US FOIA stated the CNA's were to empty the NJ Exec Order 26.4b1 and reported the amount to the nurses. The US FOIA stated the nurses were responsible to record the NJ Exec Order 26.4b1 in the eTAR. The US FOIA further stated if there was NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 then she would report it to the resident's Physician and the US FOIA (b)(6)) and document the changes in the progress notes.

On 3/5/25 at 9:37 AM, during an interview with the surveyor, CNA #2 who worked the day shift stated she would report the NJ Exec Order 26.4b1 to the nurse at 2:00 PM before her shift ended.

On 3/5/25 at 10:00 AM, during an interview with

Assurance Performance Improvement committee to identify trends and concerns.

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F 690	Continued From page 59 the surveyor, the US FOIA (b)(6) stated the NJ Exec Order 26.4b1 was recorded in the eTAR. The US FOIA (b)(6) explained the process. The CNA would empty the NJ Exec Order 26.4b1, reported the NJ Exec Order 2 to the nurse, the nurse would document the NJ Exec Order 26.4 in the eTAR. The US FOIA (b)(6) reviewed the eTAR with the surveyor and verified also the missing documentation. The US FOIA (b)(6) stated it was important to measure and record the NJ Exec Or in the eTAR to ensure that the NJ Exec Order 26 was NJ Exec Order 2 and there was NJ Exec Order 26.4b1. The US FOIA (b)(6) stated there were "too many gaps" in the eTAR, the staff needed to be educate to complete all their documentation in a timely manner. On 3/6/25 at 12:52 PM, the survey team met with the facility administrative staff, informed them of the above concerns and asked to provide any additional information on the next day. On 3/7/25 at 12:49 PM, during the exit conference, no additional information was provided. A review of the facility's "Indwelling Catheter Justification and Removal" undated policy included: It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling catheter, unless clinically necessary and promotes urinary continence of its residents, in accordance with State and Federal Regulations. NJAC 8:39-19.4(a)5, 27.1(a)(b)	F 690		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		5/2/25

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F 695	Continued From page 60 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Repeat Deficiency Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to administer [redacted] according to the physician order and ensure [redacted] equipment was stored properly. This deficient practice was identified for 1 of 1 resident (Resident #341) reviewed for [redacted] care and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse	F 695	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. The [redacted] for resident #341 was immediately [redacted] as per Physician's order upon discovery of the deficient practice during the survey period. Vital signs were taken including [redacted] and all were within [redacted] A plastic bag for storage of [redacted] when not in use was also made available for this resident. Resident #341 was discharged from the facility on [redacted] On 2/28/2025, Registered Nurse assigned to the resident verified the physician's order for [redacted] administration and corrected the [redacted] accordingly. On 2/28/2025, the Registered Nurse discarded the [redacted] that was not	

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F 695	Continued From page 61 Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 2/27/25 at 10:46 AM, the surveyor observed Resident #341 in their bed. The resident was receiving NJ Exec Order 26.4b1 [redacted]. The NJ Exec Order 26.4b1 was observed to be set at [redacted]. The surveyor observed a resident's wheelchair next to their bed with an [redacted] tank behind the wheelchair, connected to an undated [redacted] which was wrapped around the handle of the [redacted]. The [redacted] was not in any protective covering and was exposed to the environment. On 2/28/25 at 11:55 AM, the surveyor observed Resident #341 eating lunch in their room. The resident was receiving [redacted] at NJ Exec Order 26.4b1, which was connected to the NJ Exec Order 26.4b1. The surveyor observed the wheelchair next to resident's bed with [redacted] behind the wheelchair and [redacted] was connected. The [redacted] was wrapped around the handle of the [redacted] and was not in any protective covering as on [redacted]. On 2/28/25 at 12:28 PM, the surveyor reviewed the medical records of Resident #341 which revealed:	F 695	properly stored. A new NJ Exec Order 26.4b1, dated, labeled and placed in plastic bag, was provided to Resident #341. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents requiring oxygen have the potential to be 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 would not recur. On 3/17/2025, the Assistant Director of Nursing/designee educated all nurses to ensure that oxygen therapy is administered according to physician's order. On 3/17/2025, the Assistant Director of Nursing/designee educated all staff to ensure that oxygen equipment is stored in a sanitary manner when not in use in order to prevent spread of infection. The Unit Manager/designee will observe ALL residents on oxygen therapy daily for the next 4 weeks then weekly thereafter according to physician's order and that oxygen equipments are stored properly. Results of the audits will be submitted to the DON.	

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F 695	Continued From page 62 A review of Resident #341's Admission Record (an admission summary) reflected that Resident #341 was admitted to the facility with diagnosis that included but were not limited to; [redacted]. A review of the Annual Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed the resident had a score of [redacted] out of 15 on the Brief Interview for Mental Status (BIMS), indicative of [redacted]. Further review of the MDS indicated that Resident #341 received [redacted] The [redacted] Order Summary Report (OSR) revealed a Physician Order with an initial date of [redacted] for [redacted] every shift for [redacted] On 2/28/25 at 12:38 PM, during an interview with the surveyor, the [redacted]) stated that she would make rounds in the beginning of her shift to make sure the resident was receiving [redacted] as per the physician' order. The [redacted] further stated that she would date and store the [redacted] in a plastic bag when the [redacted] was not being used to prevent infection. The [redacted] informed the surveyor that Resident #341 was receiving [redacted]. In the presence of the surveyor, the [redacted] reviewed the physician order and verified that the resident was to have the [redacted] at [redacted] The surveyor accompanied the [redacted] to the resident's room and observed resident's [redacted] was [redacted] at [redacted]. The [redacted] changed the [redacted] to [redacted]. The [redacted] discarded the [redacted] attached to the [redacted] and stated, the [redacted] should be dated and stored in a plastic	F 695	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. The DON will submit results of the audits to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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F 695	Continued From page 63 bag. On 2/28/25 at 1:27 PM, during an interview with the surveyor, the US FOIA (b)(6)) stated that her expectation was that the nurses would make rounds in the beginning of their shift, and ensure that the physician orders for NJ Exec Order 26 delivery was being followed. On 3/6/25 at 12:52 PM, the survey team met with the US FOIA (b)(6) and the US FOIA (b)(6) and informed them of the above concerns. The US FOIA (b)(6)) acknowledged that the NJ Exec should be placed in a bag to prevent infections. A review of the facility policy "Oxygen Administration" with a revised date of 6/23 included: Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the residents' goals and preferences. Under Procedure: 5.e Keep delivery devices covered in plastic bag when not in use. A review of the facility policy "Physician Orders Policy" with a revised date of 5/23 included under procedure: 4. A licensed nurse or professional shall provide the care and services for a resident based on a physician order, when indicated. On 3/7/25 at 12:49 PM, during the exit conference, no additional information was provided. NJAC 8:39-11.2(b); 27.1(a)	F 695		
F 698 SS=E	Dialysis	F 698		4/18/25

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	315344	A. BUILDING _____ B. WING _____	C 03/10/2025

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F 698	Continued From page 64 CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and document review, it was determined that the facility failed to ensure that staff monitored, assessed and documented the care of a NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) This deficient practice was identified for 2 of 2 residents reviewed (Resident #2 and Unsampled Resident #1), and for 2 of 2 staff observed for NJ Exec Order 26 NJ Ex Order 26.4(b)(1) care, and was evidenced by the following: On 2/27/25 at 1:26 PM, the surveyor observed Resident #2 in bed, and observed that Resident #2 had an NJ Exec Order 26.4b1 The resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4 and the resident was NJ Exec Order 26.4b1 with the surveyor. At that time, a review of Resident #2's medical record revealed the following: The Admission Record revealed diagnoses which included, but were not limited to; NJ Exec Order 26.4b1 The Annual Minimum Data Set (MDS) assessment dated NJ Exec Order 26.4b, revealed that the resident received a score of NJ out of 15 on the Brief Interview for Mental Status (BIMS) and was	F 698	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. On 3/6/2025, the Assistant Director of Nursing/designee re-educated Licensed Practical Nurse (LPN) #1 and LPN#2 on the assessment, monitoring and documentation of care for a patient with a NJ Exec Order 26.4b1 . On 3/6/2025, staff continues to monitor, assess and document the care of NJ Exec Order 26.4b1 for Resident #2 and Unsampled Resident #1. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving dialysis have the potential to be affected by the deficient practice.	

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F 698	Continued From page 65 NJ Exec Order 26.4b1 . The NJ Exec Order 26.4b1 Physician Order (PO) Sheet revealed a PO with an original date of NJ Exec Order 26.4b1, to check for NJ Exec Ord and NJ Exec Ord every shift. The surveyor reviewed the resident's current care plan, last revised NJ Exec Order 26.4b1 The Care Plan had a Focus for NJ Exec Order 26.4b1 related to ESRD with an intervention to monitor the NJ Exec Order 26.4b1 for signs and symptoms of NJ Exec Order 26.4b1 . The surveyor reviewed the Treatment Administration Record (TAR) and observed that staff initialed the TAR for all 3 shifts (7 AM-3PM, 3 PM-11PM and 11 PM-7AM) indicating that the NJ Exec [redacted] was checked by the nurse for NJ Exec Order 26.4b1) and NJ Exec Order 26.4b1 [redacted] . On 2/28/25 at 11:16 AM, the surveyor reviewed the dialysis communication book for Resident #2 with the Licensed Practical Nurse (LPN #1). LPN #1 verified the NJ Exec Order 26 schedule, and confirmed that Resident #2 had a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 . The communication form was signed by the nurse and reflected that the nurse checked for NJ Exec Order 26.4b1 documented the vital signs and checked the patency of the NJ Exec Order 26.4b1 prior to NJ Exec Order 26.4b That same day at 11:30 AM, the surveyor escorted the nurse to the room, the nurse showed the NJ Exec Order 26.4b1 to the surveyor and informed the surveyor that the dialysis center provided care for the NJ Exec Order 26.4b1 , and she was not responsible for anything else besides documenting the vital signs, and to assess the resident for NJ Exec Ord On 3/05/25 at 9:30 AM, the surveyor interviewed LPN #1 regarding care of the NJ Exec Order 26.4b1 .	F 698	ELEMENT 3 What measures will be put into place or systemic changes will be made to ensure that the deficient practice would not recur. The Assistant Director of Nursing/designee provided education to all licensed nurses on 3/17/2025 related to the care of residents receiving hemodialysis specifically the care of dialysis access site. A competency evaluation related to care of dialysis access site will be conducted by the Assistant Director of Nursing/designee for 5 (five) nurses weekly x 5 weeks. 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. The Director of Nursing/designee will review the results of the competency evaluation monthly. The results of these observations will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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F 698	Continued From page 66 LPN #1 confirmed that she did "not have to do anything" prior to the resident leaving for [redacted]. The nurse accompanied the surveyor to the resident's room and showed the [redacted] to the surveyor, she again stated clearly that she does not have to check for anything. She informed the resident of the [redacted] treatment, monitored and documented the vital signs on the communication form and stated that the [redacted] center cared for the [redacted]. On 3/05/25 at 10:05 AM, the surveyor interviewed LPN #2 on the [redacted] side of the Unit regarding the care of the [redacted]. LPN #2 accompanied the surveyor to another resident's (Unsampled Resident #1) room who also had an [redacted] on the [redacted]. LPN #2 stated that the [redacted] should have been removed four hours after the [redacted] treatment. LPN #2, then stated, in the presence of the [redacted], confirmed that she checked the vital signs, informed the resident of the [redacted] treatment, and would also assess the resident for [redacted] LPN #2 was not aware that she had to check the [redacted] for [redacted] prior to [redacted]. The surveyor reviewed the [redacted] policy with LPN #2, who stated, that she had not been aware of the policy to monitor the [redacted] for patency. The surveyor reviewed the facility provided orientation packet and the yearly competency evaluation provided by the nurse educator on 3/5/25 at 11:25 AM. There was no competencies or education related to the care of the [redacted] During an interview on 03/06/25 at 01:30 PM, the surveyor brought the above concerns to the	F 698		

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F 698	Continued From page 67 attention of the US FOIA (b)(6) and US FOIA (b)(6). Both confirmed that since the surveyor brought the concern to the attention of the facility, nursing staff had been provided with in-service education on the care of the NJ Exec Order 26.4b1 On 03/07/25 at 11:00, during the exit conference held with the US FOIA (b)(6) . The US FOIA (b)(6) confirmed that both nurses were not aware to check the NJ Exec Order 26.4b1. The policy titled, "Dialysis Policy" revised 07/23, reflected the following: It is the policy of this facility to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. The policy indicated to monitor for patency of dialysis access site.	F 698		
F 812 SS=F	NJAC 8:39- 27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		4/30/25

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F 812	Continued From page 68 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review it was determined that the facility failed to ensure the proper rinse temperature was consistently maintained for the dish machine and dishware was appropriately dried to limit potential bacterial growth and the potential for food borne illness. The deficient practice was evidenced by the following: On 03/04/25 at 9:28 AM, the surveyor observed the dish machine in use cleaning the breakfast dishes. The surveyor observed, with staff, the final rinse temperature was 172 degrees Fahrenheit (F). Dietary Staff (DS #1) was also observed removing the plates from the dish machine with his bare hands and he proceeded to wipe the plates with a rag, and then placed them on a rack. The US FOIA (b)(6) was present and informed DS #1 to not wipe the dishes. The surveyor again observed DS #2 loading the dish machine with soiled items and then asked DS #2 what the temperatures for the wash and rinse should be. DS #2 stated, wash should be 160 F and rinse should be 180 F. The surveyor observed the rinse temperature which	F 812	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. Dish Machine Repair Company was called and readily fixed the dishwashing machine on 3/4/2025. The dish machine was put back in operation on 3/4/2025at an acceptable wash and final rinse temperatures. There was 1 (one) meal period that disposable utensils were used. ELEMENT 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice by failing to maintain consistent acceptable final rinse temperature to prevent bacterial growth and food borne illness.	

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F 812	Continued From page 69 only reached 170 F as the items when through, when the surveyor asked the DS #2 why the temperature did not reach 180 F, DS #2 stated, "sometimes it varies". DS #2 then placed a rack that contained soiled insulated tray lids into the machine and the rinse temperature reached 165 F. The surveyor asked the US FOIA (b) what the temperature should be for the rinse and the US FOIA (b) stated 180 F, and he then observed as items were placed in the dish machine that the temperature was 165 F for the rinse. The US FOIA (b) stated he was going to check the hot water booster and shut the machine down. The US FOIA (b) stated he checked it in the morning and it was working. The surveyor requested the dish machine policy and reviewed a temperature log affixed to the wall that indicated the rinse temperature was 186 F on 03/04/25. On 03/04/25 at 1:18 PM, the US FOIA (b)(6) confirmed that the dish machine was not being used until the machine was fixed. On 03/05/25 at 9:41 AM, the surveyor interviewed the repairman for the dish machine via telephone. The repairman stated, the water pressure was too high and he adjusted it because when the pressure was too high the waster went through the machine too quickly and did not have enough time to heat up to the appropriate temperature. The surveyor asked if the facility should have been using the machine if the rinse temperature was not 180 F. The repairman stated, the rinse temperature should have been 180 F and the temperature was "and obvious indication" regarding the dish machine function. The Dishwashing Policy, undated, revealed #4:	F 812	ELEMENT 3 What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All food service employees including the US FOIA (b)(6)) were given an in-service by the Registered Dietitian as to the Dishwashing Policy of checking the temperature gauges for wash (160-175) and final rinse (180 deg) prior to using the dishwashing machine and the temperatures is being maintained throughout the dishwashing process. All food service employees, including the U.S. FOIA were given an in-service about air drying process of all kitchen equipment and utensils. A return demonstration of understanding and competency of education given to food service employees and FSD. 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. The Administrator and/or FSD (Food Service Director) will check the temperature gauges (wash and final rinse) during dishwashing process 3x daily for the next 4 weeks, then once daily thereafter The temperature recorded on the log will be checked daily by the FSD. Any deviation from the acceptable range will be reported immediately to the FSD.	

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F 812	Continued From page 70 ...Check temperature gauges before and during dishwashing to determine is wash and rinse temperatures being maintained. Wash temperatures should be 160- 175 degrees and final rinse temperature greater than 180 ... Any deviations in temperatures will be reported to maintenance. NJAC 8:39-17.2(g)	F 812	The FSD will observe the drying process of all kitchen utensils and equipment 3x day for 4 weeks. Results of these daily observations will be submitted to the QA committee quarterly for review and recommendations.	

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	060910	A. BUILDING: _____ B. WING _____	C 03/10/2025

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S 000	Initial Comments Complaint #s: NJ 167925, 169842, 181072 Survey Date: 3/10/25 Census: 130 Sample: 27 + 1 closed record The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to a) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey and (b) train the two (2) appointed designated staff members and the facility staff within the required time frames for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus [a virus that attacks cells that help the body fight infection] positive)	S 560	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Administrator and Director of Nursing met with the Staffing Coordinator on March 17, 2025 to ensure that the minimum direct care staff-to-resident ratios are met for every shift. On April 4, 2025, the Administrator and Social worker completed the training for the LGBTQI+ (Lesbian, Gay, Bisexual,	4/18/25

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

Electronically Signed | 03/28/25

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S 560	Continued From page 1 program. This deficient practice was evidenced by the following: a) Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for 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 10 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 14 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	S 560	Transgender, Queer/questioning [one's sexual or gender identity], Intersex [person is born with a combination of male and female biological traits] positive) and HIV+ (Human Immunodeficiency Virus) program to become the facility's Designated Representatives and trainors. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents at the facility have the potential to be affected by the deficient practices. Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The facility Administrator and the Social Services Director are enrolled in and will recertify for the LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Queer/questioning [one's sexual or gender identity] train-the-trainer program on April 4, 2025. This facility recognizes the shortage of Certified Nurse Aides (CNAs) during the dates mentioned on the statement of deficiencies. This facility has hired 2 full-time CNA and 1 Per-diem CNA. Optimacare company has hired a full-time recruiter to fill-in all open positions. Aggressive advertisement and recruitment on-going. The facility will continue to offer incentives	

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S 560	Continued From page 2 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 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 ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the following weeks revealed: 1. For the 2 weeks of Complaint staffing from 08/27/2024 to 09/09/2023, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -08/27/23 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. -09/02/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -09/03/23 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs. -09/04/23 had 14 CNAs for 126 residents on the	S 560	(Overtime, Bonus etc.) to current working staff. The Director Of Nursing/designee will check staffing daily including the weekend and holidays for adequacy and compliance for 4 weeks then monthly thereafter. Element 4 -How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of this review will be submitted to the QA committee quarterly for comments and recommendations.	

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S 560	Continued From page 3 day shift, required at least 16 CNAs. 2. For the 2 weeks of Complaint staffing from 11/12/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -11/12/23 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -11/18/23 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. 3. For the 2 weeks of Complaint staffing from 11/17/2024 to 11/30/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -11/17/24 had 16 CNAs for 134 residents on the day shift, required at least 17 CNAs. -11/24/24 had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. -11/30/24 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. 4. For the 2 weeks of staffing prior to survey from 02/09/2025 to 02/22/2025, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -02/09/25 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. -02/15/25 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. -02/16/25 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. -02/17/25 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs.	S 560		

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 _____	C 03/10/2025

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) COMPLETE DATE
S 560	Continued From page 4 On 3/7/25 at 10:24 AM, during an interview with the surveyor, the Staffing Coordinator (SC) stated she was aware of the State's minimum staffing ratio. The SC further stated the facility was meeting the ratios. b) Reference: New Jersey Department of Health (NJDOH) memo, dated 04/19/22, "Statutory Amendments Regarding the Rights of LGBTQI+ and HIV+ Residents of Long-Term Care Facilities Pursuant to N.J.S.A. 26:2H-12.101-10 7." The memorandum concerned the rights of LGBTQI+ and HIV+ residents of long-term care facilities; N.J.S.A. 26:2G-12, 101-107 ("LGBTQI+ Law"), and a facility's responsibilities under the LGBTQI+ Law. The LGBTQI+ Law was signed on March 3, 2021 and took effect on August 30, 2021. The requirements of the LGBTQI+ Law will be included in N.J.A.C 8:39 in future rulemaking. Specifically, the LGBTQI+ Law establishes specific rights and protections for lesbian, gay, bisexual, transgender, undesignated/non-binary, questioning, queer, and intersex ("LGBTQI+) older adults and people living with HIV ("HIV+) in long-term care facilities ("Facilities"). The LGBTQI+ Law ensures that LGBTQI+ and HIV+ residents in facilities have equitable access to health care and provides the same legal protections as everyone else regardless of their sexual orientation or health status. Prohibited Actions The LGBTQI+ Law prohibits facilities from taking any of the following actions based on a person's sexual orientation, gender identity, gender expression, intersex status, or HIV status:	S 560		

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 _____	C 03/10/2025

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

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S 560	Continued From page 5 1. Denying admission to a facility, transferring or refusing to transfer a resident within a facility or to another facility, or discharging, or evicting a resident from a facility; 2. Denying a request by residents to share a room; 3. Where rooms are assigned by gender, assigning or reassigning a room based on gender, subject to the provisions of 42 C.F.R. 483.10 (e) (5); 4. Forbidding a resident from, or harassing a resident who seeks to use or does use, a restroom available to other residents of the same gender identity, regardless of whether the resident is making a gender transition, has taken or is taking hormones, has undergone gender affirmation surgery, or presents as gender-nonconforming. For the purposes of this paragraph, harassment includes, but is not limited to, requiring a resident to show identity documents in order to gain entrance to a restroom available to other persons of the same gender identity; 5. Repeatedly failing to use a resident's chosen pronouns or the name the resident chooses to be called, despite being clearly informed of the resident's choice; 6. Denying a resident from wearing preferred clothing, accessories, or cosmetics, or participating in grooming practices; 7. Restricting a resident's right to visit and have conversations with other resident's or with visitors including the right to have consensual sexual	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 6 relations; 8. Denying, restricting, or providing unequal medical or non-medical care, which is appropriate to the resident's bodily needs and organs, or providing medical or nonmedical care that, to a similarly-situated resident, causes avoidable discomfort or unfairly demeans the resident's dignity; and 9. Declining to provide any service, care, or reasonable accommodation requested by the resident, subject to the provisions of 42 C.F.R. 483.10(c)(6). Resident Records Additionally, facilities are required to ensure that resident records include the resident's gender identity and the resident's chosen name and pronouns, as indicated by the resident. Confidentiality The LGBTQI+ Law also requires facilities to maintain the confidentiality of certain resident information. Unless required by state or federal law, personal identifying information regarding a resident's sexual orientation, whether a resident is transgender or undesignated/non-binary, a resident's gender transition status, a resident's intersex status, or a resident's HIV status shall not be disclosed. Further, facilities are required to take appropriate steps to minimize the likelihood of inadvertent or accidental disclosure of such information to other residents, visitors, or facility staff, except to the minimum extent necessary for facility staff to perform their duties. Unless expressly authorized, facility staff not	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 7 directly involved in providing direct care to a transgender, undesignated/non-binary, intersex, or gender-nonconforming resident, shall not be present during a physical examination of, or the provision of personal care to, that resident if the resident is partially or fully unclothed. Doors, curtains, screens, or other effective visual barriers to providing bodily privacy, when partially or fully unclothed, shall be used. Informed consent is required in relation to any non-therapeutic examination or observation of, or treatment provided to, a resident of the facility. Facilities shall also provide transgender residents with access to transition-related assessments, therapy, and treatments as having been recommended by the resident's health care provider, including, but not limited to, transgender-related medical care, including hormone therapy and supportive counseling. Violations A facility or an employee of a facility that violates the requirements of the LGBTQI+ Law is subject to civil or administrative action. Training Facilities shall designate two employees, including on employee representing management at the facility and one employee representing direct care staff at the facility, to receive in-person training within six months after the effective date of the LGBTQI+ Law. The required training shall be provided by an entity that has demonstrated expertise in identifying the legal, social, and medical challenges faced by, and in creating safe and affirming environments for LGBTQI+ and HIV+ seniors who reside in long-term care facilities in New Jersey.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 8 The required training shall address: 1. Caring for LGBTQI+ seniors and seniors living with HIV; 2. Preventing discrimination based on sexual orientation, gender identity or expression of intersex status, and HIV status; 3. The definition of terms commonly associated with sexual orientation, gender identity and expression, intersex status, and HIV; 4. Best practices for communicating with or about LGBTQI+ and HIV+ seniors, including the use of a resident's chosen name and pronouns; 5. A description of the health and social challenges historically experienced by LGBTQI+ and HIV+ seniors, including discrimination when seeking or receiving care at long-term care facilities, and the demonstrated physical and mental health effects within the LGBTQ community; 6. Strategies to create a safe and affirming environment for LGBTQI+ and HIV+ seniors, including suggested changes to facility policies and procedures, forms, signage, communication between residents and their families, activities, and staff training and in-services; and 7. An overview of the provisions of LGBTQI+ Law. Facilities are responsible for maintaining records documenting the completion of the training, as well as the cost of providing the training. During an interview with the surveyor conducted on 03/04/25 at 9:08 AM, and again confirmed on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 9 03/07/25 at 11:01 AM, the Licensed Nursing Home Administrator was unable to provide proof of 2 employees having the LGBTQI+ training (which in included the 1 staff member representing administration and 1 staff member representing direct care staff), as required by state law.	S 560		
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview on 3/10/25, in the presence of the Administrator (Admin) and Corporate Staff (CS), it was determined the	S2315	lement 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient	4/18/25

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 _____	C 03/10/2025

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S2315	Continued From page 10 facility failed to ensure the facility's disaster planner met with county emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if officials were unavailable for this purpose, the facility shall notify the State Office of Emergency Management (OEM). The deficient practice had the potential to affect all residents and was evidenced by the following: The surveyor conducted record review on 3/10/25, of the Emergency Preparedness Plan (EPP), which revealed the municipal emergency management coordinator had not conducted an annual review and evaluation of the EPP with the facility staff. There was no documentation of annual review and evaluation with the county emergency management coordinator provided. In an interview at 11:15 AM, the Admin and CS confirmed the county emergency management did not review the facility's EPP. The facility Administration were informed of the deficient practice at the Life Safety Code exit conference on 3/10/25 at 12:45 PM.	S2315	practice. A letter was sent to State and County Office of Emergency Management to notify about the schedule to review, evaluate and update the facility's Emergency Preparedness Plan (EPP). Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents at the facility have the potential to be affected. Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. An invitation letter was sent to the county and municipal Emergency Management coordinators to review the facility's EPP annually. Element 4 -How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Administrator will review and follow-up the response of the county and municipal emergency management to satisfy the requirement for an annual review.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315344 Y1	A. Building B. Wing Y2	5/22/2025 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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0677	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	04/18/2025	LSC	04/18/2025	LSC	04/18/2025
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/10/2025	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315344 Y1	A. Building B. Wing Y2	5/22/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0558	Correction	ID Prefix F0609	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(3)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	04/18/2025	LSC	04/18/2025	LSC	04/18/2025
ID Prefix F0610	Correction	ID Prefix F0640	Correction	ID Prefix F0655	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(a)(1)-(3)	Completed
LSC	04/18/2025	LSC	04/18/2025	LSC	04/18/2025
ID Prefix F0656	Correction	ID Prefix F0677	Correction	ID Prefix F0684	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25	Completed
LSC	04/18/2025	LSC	04/18/2025	LSC	04/18/2025
ID Prefix F0688	Correction	ID Prefix F0689	Correction	ID Prefix F0690	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(e)(1)-(3)	Completed
LSC	04/18/2025	LSC	04/18/2025	LSC	04/18/2025
ID Prefix F0695	Correction	ID Prefix F0698	Correction	ID Prefix F0812	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	05/02/2025	LSC	04/18/2025	LSC	04/30/2025

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/10/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060910 Y1	A. Building B. Wing Y2	5/22/2025 Y3

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

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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	04/18/2025	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	
3/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060910 Y1	A. Building B. Wing Y2	5/22/2025 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S2315	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-31.6(i)(1-2)	Completed	Reg. #	Completed
LSC	04/18/2025	LSC	04/18/2025	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	
3/10/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING **01** B. WING _____	**03/10/2025**

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
E 000	Initial Comments This facility was not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		4/18/25

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

Electronically Signed | 03/31/2025

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 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
	315344	A. BUILDING **01** B. WING _____	**03/10/2025**

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
E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents on 3/10/25, it was determined the facility failed to establish and maintain the facility transfer contracts and agreements at least annually in accordance with Appendix Z, §483.73(a): Emergency Plan. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility documents at 10:05 AM, revealed that facility contracts and transfer agreements were not updated at least annually. The following contracts and transfer agreements not annually updated: 1. Policy & Procedure Resident and Staff tracking in emergencies revised 11/16/2022. 2. Staffing & Volunteer Coverage revised 12/7/2017. 3. Communication Contingency Plan revised	E 004	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Administrator and her designee immediately revised , updated and approved all contracts and transfer agreements mentioned in the citation. Attachements of proof to follow. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The contracts and transfer agreements	

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E 004	Continued From page 2 11/16/2022. 4. Method for sharing Information revised 11/16/2022. 5. Communication Plan revised 12/6/2017. 6. Fire Policy revised 11/16/2022. 7. Policy & Procedure water emergency/interruption of water revised 11/16/22. 8. Missing resident Policy & Procedure revised 11/16/2022. 9. Winter Storm safety precautions revised 11/16/22. 10. Disaster Policy & Procedures 11/16/2022. 11. Emergency fuel supply 1/7/2022. 12. Fire Drills policy 11/20/22. 13. Testing of Alarm system policy revised 11/20/2022. 14. Agreement for Ambulance Service 3/1/2020 under old facility name (Alaris Health at Castle Hill). 15. Transfer Agreements under old facility name (Alaris Health at Castle Hill). 16. General Staff Training revised 11/1/2017. 17. Alaris Health at Castle Hill evacuation procedures 6/6/18 (elite ambulance).	E 004	are now revised and updated on the following areas: 1) Policy & Procedure Resident and Staff tracking in emergencies; 2) Staffing & Volunteer Coverage; 3) Communication Contingency Plan; 4) Method for sharing Information; 5) Communication Plan; 6) Fire Policy; 7) Policy & Procedure Water emergency/ Interruption of Watr; 8) Missing Resident Policy & Procedure; 9) Winter Storm safety Precautions; 10) Disaster Policy & Proceure; 11) Emergency Fuel Supply; 12) Fire Drills Policy; 13) Testing of Alarm System Policy; 15) Transfer Agreements; 16) General Staff Training; 17) Evaluation Procedure; 18) National Notification Infectious Conditions; 19) Policy & Procedure for Ebola Outbreak; 20) Policy & Procedure for Zika Outbreak. The Administrator will review all manuals, policy, procedures and protocols every 3 months (quarterly) to ensure all are updated and revised as necessary for the next 12 months. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of the reiew will be reported to the QA committee who meets quarterly during quarterly meetings for comment	

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E 004	Continued From page 3 18. National Notification infectious conditions revised 11/10/22. 19. Policy & Procedure for Ebola Outbreak 11/16/2022. 20. Policy & Procedure for Zika Outbreak 11/16/2022. In an interview at the time of document review, the US FOIA (b)(6) indicated the above documents were not updated as of this survey. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 3/10/25 at 12:45 PM.	E 004	and recommendations	
E 018 SS=F	NJAC 8:39-31.2(e), 31.6(i) Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the	E 018		4/30/25

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E 018	Continued From page 4 following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.	E 018		

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E 018	Continued From page 5 *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, it was determined that the facility failed to have a system in place in the Emergency Preparedness (EP) manuals to track the location of on duty staff and sheltered residents during an emergency. This deficient practice was identified for all resident units and the facility's main EP manual and was evidenced by the following: On 03/10/25 at 11:45 AM, the surveyor reviewed the provided EP manual from the US FOIA (b)(6) The chain of command was provided, but did not include the staff names and contact information in the event of an emergency. In an interview, the US FOIA (b)(6) confirmed the findings at the exit conference.	E 018	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Administrator and her designee developed and approved a system in place in the Emergency Prepareness manual to track the location of on duty staff and sheltered residents during emergency. Attachement of proff to follow. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation.	

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E 018	Continued From page 6 The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.6	E 018	ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The facility has now a policy on tacking staff on duty and residents in the building in event of an emergency The Chain of Command in the Emergency Preparedness Manual now have the names and contact information in the event of an emergency. The Administrator will review the Emergency Preparedness manual every 3 months (quarterly) for the next 12 months to check any need for update and revision including the chain of command. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of these audits will be submitted to the QA committee who meets quarterly for review & recommendations.	
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an	E 029		4/30/25

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E 029	Continued From page 7 emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 3/10/25 in the presence in the US FOIA (b)(6) it was determined that the facility failed to ensure that the Emergency Preparedness Communication Plan was reviewed and updated annually in accordance with Title 42 Code of Federal Regulations (CFR) at 483.73 LTC facilities. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 3/10/25 of the facility's Emergency Preparedness Plan and Program (EPP), revealed the emergency preparedness communication plan was last reviewed on 12/6/2017 for (Alaris Health Castle Hill) old facility name. In an interview, the US FOIA (b)(6) indicated she did not update the Emergency Preparedness Manual. The US FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.6	E 029	lement 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Administrator and her designee reviewed, updated and approved the Communication Plan in the Emergency Preparedness Manual. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents at the facility have the potential to be affected by staffing shortage any day. Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The facility's communication plan as part of the Emergency Preparedness protocol was updated by the Administrator. The Administrator or her designee will review and update this Communication policy every 3 months (quarterly) for the next 12 months as part of the Emergency Preparedness Manual. Element 4 -How the facility will monitor its	

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E 029	Continued From page 8	E 029	corrective actions to ensure that the deficient practice is being corrected and will not recur. The result of the review will be submitted to the QA committee who meets quarterly for any recommendations.	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2),	E 041		5/20/25

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E 041	Continued From page 9 §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.	E 041		

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E 041	Continued From page 10 (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop an Emergency Preparedness plan to ensure the emergency generator provides continuous power during an emergency in accordance with NFPA 101 and NFPA 110. The deficient practice had the potential to affect all residents and was evidenced by the following: Document review on 3/10/25 revealed no policy related to the emergency power to the electric fire pump.	E 041	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. A detailed policy was developed to be in compliant with the NFPA 101 and NFPA 110. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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E 041	Continued From page 11 In an interview at the time, the US FOIA (b)(6) and US FOIA (b)(6) were unaware of the requirements to include policies related to the fire pump and continuing normal operation of the building due to power failure. The US FOIA (b)(6) provided an Emergency Generator Circuits document dated and revised: 2/1/13. The report did not indicate that the electric fire pump was on any of the emergency generator circuits. The facility's US FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 3/10/25 at 12:45 PM. N.J.A.C 8:39-31.2(e)	E 041	All residents at the facility have the potential to be affected by the this deficient practice ensuring that the facility has continuous normal operation following of the policy of the building in event of power failure. Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. To ensure that the policy is followed regularly, the maintenance director or designee will perform the weekly generator testing (with 1 full load monthly), including the checking of fluid levels , hoses, connections and power source to supply the electric fire pump as per policy. These tasks will be done weekly and remain on-going. Element 4 -How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of this tests will be submitted to the QA committee who meets quarterly for comments & recommendations.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 03/06/2025 to 03/10/2025 and Optima Care Castle Hill was found to be in noncompliance with the requirements for participation in	K 000		

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(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
K 000	Continued From page 12 Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The nursing home building construction was stated to be in the 90's with no current major renovations or noted additions. It is a 6-story building Type II (222) protected construction and is fully sprinklered. The facility has 12 smoke zones. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator (155 KW) is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has an electric fire pump. The facility has 215 certified beds. At the time of the survey the census was 130.	K 000		
K 232 SS=F	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by:	K 232		5/12/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING 01 B. WING _____	03/10/2025

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K 232	Continued From page 13 Based on observation and interview on 3/7/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that the width of aisles or corridors serving as exit access shall be at least 4 feet and maintained a clear and unobstructed width to provide the convenient removal of non-ambulatory patients on stretchers in accordance with NFPA 101(2012) section 19.2.3.5. This deficient practice had the potential to affect staff and residents in this area and was evidenced by the following: An observation at 10:00 AM revealed that the floor #2 service exit/egress corridor outside the conference room was being used to store: out of service rebreathers, approximately 6 resident beds, metal side bars, electric Hydrocullator and out of service PTAC units. The facility was currently not maintaining a clear and unobstructed exit/egress width. In an interview at the time of observation, the US FOIA and US FOIA both confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice during the Life Safety Code exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.2(e)	K 232	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The large equipment that was observed to obstruct over the required width limit of 4 feet clearance are now removed and cleared from the second floor corridor. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All ambulatory and/or non- ambulatory residents on a strecher or non- strectcher who will need an easy accessibility through this corridor in event of emergency have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The service exit/egress on the second floor corridor is now clear and unobstructed of any stored equipment over 48". The Maintenance Director gave an in-service education about maintaining an acceptable hallway clearance to maintenance and housekeeping staff. The Administrator or Maintenance Director or his designee will conduct inspection as to the clearance of all exit corridors and hallways daily for the next 4 weeks then monthly thereafter. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the	

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K 232	Continued From page 14	K 232	deficient practice is being corrected and will not recur. The results of the daily inspection of the appropriate clearance of the hallways will be reported to the QA committee who meets quarterly for review, comment and recommendations.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 3/7/25 in the presence of the [redacted], it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 5 of 10 areas, had the potential to affect all residents and was evidenced by the following: 1). An observation at 12:38 PM revealed that the exit to the public way in the Physical Therapy room did not have any lighting above the exterior door. 2). An observation at 12:45 PM revealed in the occupied cafe that 1 (one) light switch shut off all 9 (nine) ceiling light	K 281	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. A contracted licensed electrician has installed the following: 1) A lighting above the exterior door in the physical therapy room which serves as an exit to to the public way; 2) An emergency illumination light fixture in the cafe area has been installed; 3) Installed 3 illumination between each half stairwell floor. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. In the event of an emergency, all residents at the facility have the potential	5/12/25

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K 281	Continued From page 15 fixtures. 3). Observations revealed that 3 of 3 stairwells did not have illumination between each half floor. It was observed that each upper wall area had an electrical box where a light fixture had been previously installed. In an interview, the US FOIA and corporate staff all confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.2(e)	K 281	to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The Regional Maintenance Director gave in-service to the US FOIA (b)(6) and all Maintenance Staff about this NFPA 101:2012 Edition, Section 19.2.8 and 7.8.1.3 (2) to ensure compliance. The Maintenance Director or his designee will conduct an inspection of the functionality of all exit/egress lighting and all half stairwells weekly for the next 4 weeks then monthly thereafter. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Results of these inspections will be reported to the QA comittee who meets quarterly for review, comment and recommendations	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies	K 293		4/30/25

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K 293	Continued From page 16 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/6/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that exits were marked by an approved sign that were readily visible, and that a sign with directional indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1, 7.10, and 7.10.1.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:38 AM with the US FOIA (b)(6) revealed in the exit/egress corridors of the facility, that when the set of smoke doors by resident rooms 608 and 610 were closed from the electro-magnetic door open device, there was no illuminated exit sign each side of the smoke doors. The nearest 2nd exit was not apparent for 2 of 2 sides of the smoke doors. In interviews at the time, the US FOIA (b)(6) confirmed the observations. The US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 3/10/25 at 12:45 PM. N.J.A.C 8:39-31.2 (e)	K 293	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The smoke doors by the resident rooms in 608 and 610 now has illuminated exit signs on each sides of the electro-magnetic. ELEMENT 2 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. In case of emergency, all residents at the facility have the potential to be affected by the deficient practice. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The exits/egress corridors identified during the survey are now marked by the maintenance staff with an approved sign and are readily visible with directional indicator showing the direction of travel to reach the nearest exit. The Maintenance Director or his designee will inspect the illumination of all exit signs on all smoke doors in the building for the next 4 weeks then monthly thereafter. ELEMENT 4 - How the facility will monitor	

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K 293	Continued From page 17	K 293	its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of these inspections will be reported to the QA comittee who meets quarterly for review, comment and recommendations.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/7/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that vertical shafts between floors were enclosed with at least 2-hour fire resistant construction as per NFPA 101 2012 edition (Life Safety Code) 19.3.1 Protection of vertical Openings. This deficient practice had the potential to affect all residents and was evidenced by the following: 1). An observation at 10:00 AM with the US FOIA (b)(6) [redacted] on floor #6 revealed in the elevator corridor	K 311	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All Hatch doors on the 6th floor; 5th floor; 4th floor; 3rd floor and 2nd floor were replaced with fire resistant materials to comply with the NFPA1010 2012 editionLife Safety Code 19.3.1 There is no hatch door on the 1st floor that requires to be changed. ELEMENT 2 -How the facility will identify	5/13/25

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K 311	Continued From page 18 that the end wall had 2-hatch doors in the lower section of the wall. The US FOIA opened the hatch doors and it was observed to be an open wire/pipe shaft from the 6th floor to the first floor. The 6-story building construction type requires the hatch doors to have a 2-hour fire resistance rating. One of the 2 doors did not fully close and latch into its frame at the time of the observation. 2). An observation at 10:28 AM with the US FOIA and US FOIA on floor #5 revealed in the elevator corridor that the end wall had 2-hatch doors in the lower section of the wall. The US FOIA opened the hatch doors and it was observed to be an open wire/pipe shaft from the 6th floor to the first floor. The 6-story building construction type requires the hatch doors to have a 2-hour fire resistance rating. One of the 2 doors did not fully close and latch into its frame at the time of the observation. 3). An observation at 11:00 AM the with the US FOIA and US FOIA revealed on floor #4 in the elevator corridor that the end wall had 2-hatch doors in the lower section of the wall. The US FOIA opened the hatch doors and it was observed to be an open wire/pipe shaft from the 6th floor to the first floor. The 6-story building construction type requires the hatch doors to have a 2-hour fire resistance rating. One of the 2 doors did not fully close and latch into its frame at the time of the observation. 4). An observation at 11:49 AM with the US FOIA (b)(6) revealed on floor #3 (currently unoccupied by residents) in the elevator corridor that the end wall had 2-hatch doors in the lower section of the wall. The US FOIA opened the hatch doors and it was observed to be an open wire/pipe shaft from the 6th floor to the first floor. The 6-story building construction type requires	K 311	other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The Maintenance Director gave an in-service to all maintenance staff about the LSC requirement for all vertical shafts fire resistant construction. The MD or his designee will inspect the full closure of ALL hutch doors into its frame on all units/floors once per week for the next 3 month then monthly thereafter. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Result of the weekly & monthly inspections will be submitted to the QA committee that meets quarterly for review, comments and recommendation	

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K 311	Continued From page 19 the hatch doors to have a 2-hour fire resistance rating. One of the 2 doors did not fully close and latch (top left) into its frame at the time of the observation. 5). An observation at 12:15 PM with the US FOIA (b)(6) revealed on floor #2 in the elevator corridor that the end wall had 2-hatch doors in the lower section of the wall. The US FOIA opened the hatch doors and it was observed to be an open wire/pipe shaft from the 6th floor to the first floor. The 6-story building construction type requires the hatch doors to have a 2-hour fire resistance rating. One of the 2 doors did not fully close and latch into its frame at the time of the observation. 6). An observation at 12:33 PM with the US FOIA (b)(6) revealed on the first floor in the elevator corridor that the end wall had 2-hatch doors in the lower section of the wall. The US FOIA opened the hatch doors and it was observed to be an open wire/pipe shaft from the 6th floor to the first floor. The 6-story building construction type requires the hatch doors to have a 2-hour fire resistance rating. One of the 2 doors did not fully close and latch into its frame at the time of the observation. In an interview, the US FOIA (b)(6) both confirmed the observations. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e)	K 311		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		5/12/25

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K 321	Continued From page 20 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/6/25 and 3/7/25 in the presence of the [redacted], it was determined that the facility failed to ensure that hazardous areas were separated from other spaces by smoke resisting partitions and doors in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9. This deficient practice	K 321	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1) The elevator mechanical door with open louver and oxygen door have replaced with fire resistent doors	

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K 321	Continued From page 21 had the potential to affect all residents and was evidenced by the following: 1). Observations on 3/6/25 at 10:48 AM revealed that the floor #1 elevator machine room door contained an approximately 22-inch by 22-inch open louver that provided no protection to the exit/egress corridor. 2). Observations on 3/6/25 at 11:10 AM revealed that currently floor #3 was unoccupied by residents and the following rooms were turned into hazardous storage areas: Resident Room # 338 had no door auto-close device installed. Resident Room # 340 had no door auto-close device installed. Resident Room # 342 had no door auto-close device installed. Resident Room # 346 door rubbed into its frame, preventing it from closing. Resident Room # 348 had no door auto-close device installed. Resident Room # 351 door would not close into its frame. Resident Room # 352 door would not close into its frame. Resident Room # 353 door would not latch into its frame. 3). Observations on 3/7/25 at 1:08 PM revealed that the floor #2 oxygen room had a locked pad lock and steel hasp drilled into its frame. The door was not provided with any other hardware and could not latch into its frame. In an interview at the time, the US FOIA (b)(6) both confirmed that unoccupied resident rooms were	K 321	2) Doors in rooms 338, 340,342, and 348, now have an auto-close devise installed. Doors in rooms 346, 351, 352, and 353 now latches and readily closes into its frames without rubbing. 3) The Maintenance staff removed the locked pad in the #2 floor oxygen room and replaced it with a door knob that latches and readily closes into its frame. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The Maintenance Director or his designee will inspect 10 residents doors weekly for the next 4 weeks then monthly thereafter to check if doors has auto-close devise if needed and/or doors are freely latching into its frame. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of these audits will be reported to the QA committee that meets quarterly for review, comment and recommendations	

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K 321	Continued From page 22 being stored with combustible boxes, mattresses, furniture and miscellaneous plastic items. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/10/25 at 12:45 PM.	K 321		
K 353 SS=F	N.J.A.C 8:39-31.2 (e) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/6/25 and 3/7/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure fire sprinkler system components and smoke barriers were maintained in accordance with NFPA 13:	K 353	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1) The recessed lights on the 6th floor that	5/13/25

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K 353	Continued From page 23 2010 Edition, NFPA 25: 2011 Edition, and NFPA 101: 2012 Edition. The deficient practice had the potential to affect all residents and was evidenced by the following: 1. Observations on 3/6/25 at 10:10 AM revealed that the resident rooms on the 6th floor were provided with a (night light) recessed light fixture. The recessed light fixture was observed to have an approximately a 2-inch by 3-inch opening that went up to the unprotected roof deck above. This opening would delay the activation of the smoke detector and sprinkler head until the void above filled with smoke and heat. 2. Observations on 3/6/25 at 10:44 AM revealed that the two ground level parking areas under the footprint of the building both had open seams to the ceiling above. 3. Observations on 3/7/25 from 10:00 AM to 12:15 PM revealed that the facility electrical closets (6 of 6) had openings from oversized ceiling tile cuts where the conduit entered the ceiling above. The openings in the drop ceiling smoke barrier containing sprinkler heads would allow the smoke and hot gasses to escape into the space above the drop ceiling delaying sprinkler activation. 4. Observations on 3/7/25 at 11:40 AM revealed that the floor #3 shower room had one of 3 fire sprinkler escutcheon plates missing, leaving a gap around the ceiling tile approximately 1-inch to the decking above. 5. Observations on 3/7/25 at 11:50 AM revealed Resident room # 601 had a 2-foot by 2-foot ceiling tile out of place.	K 353	were observed with opening were now replaced with full enclosures. 2) A building construction vendor fixed all open seams on the ceiling of the ground level parking lots 3) The maintenance staff now sealed all the oversized ceiling tile cuts preventing the smoke and hot gasses to escape into the space above the drop ceiling delaying the sprinkler activation. 4) One of the 3 fire sprinkler escutcheon plates was replaced by the maintenance staff. 5)The ceiling tile in room 601 is now in place. 6) The fire sprinkler heads in the main kitchen with heavy coating of dark coating was replaced with new heads. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The Maintenance Director or his designee will conduct a routine inspection weekly of all of above Element #3: 1), 2), 3), 4), 5) and 6) for the next 3 months. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING 01 B. WING _____	03/10/2025

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

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K 353	Continued From page 24 6. Observations on 3/7/25 at 11:55 AM revealed in the main kitchen, fire sprinkler heads (4 of 8) had a heavy coating of an unknown dark substance. In an interview during the observations, the US FOIA (b)(6) confirmed the findings The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	will not recur. The results of these inspections will be reported to the QA committee that meets quarterly for review, comment and recommendations.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 3/6/25 and 3/7/25 in the presence of the US FOIA (b)(6) , it was determined that the facility failed to: A) failed to ensure the required six-year maintenance test was performed and recorded as per NFPA 10 for 9 of 37 portable fire extinguishers and B) ensure that Class K portable fire extinguishers were provided with the required instructional placard in accordance with NFPA 101:2012 Edition, Sections 9.7.4, NFPA 10:2010 Edition, Sections 5.5.5.3, A 5.5.5.3, 7.2, 7.2.2 and 7.2.4.3. These	K 355	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. A Fire Extinguisher Company was contacted to inspect all fire extinguishers to provide six-year maintenance test and record. B) The Class K fire extinguisher in the kitchen now have an required instructional placard stating that the fire protection system shall be actuated prior to to using	5/2/25

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K 355	Continued From page 25 deficient practices had the potential to affect all residents and were evidenced by the following: A). Observations on 3/6/25 and 3/7/25 revealed that in-service fire extinguishers dated 2018, were not provided with the required six-year maintenance test as per NFPA 10 in various areas throughout the facility. B). An observation on 3/7/25 revealed that the Class K fire extinguisher in the kitchen was not provided with the required instructional placard stating that the fire protection system shall be actuated prior to using the portable K-type fire extinguisher. In an interview at the time, the US FOIA (b)(6) both confirmed the observations and recorded locations throughout the facility. The facility's US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 3/10/25 at 12:45 PM. N.J.A.C 8:39-31.2(e) NFPA 10	K 355	the portable K-type fire extinguisher. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The Maintenance Director or his designee will conduct inspection of all fire extinguishers weekly for the next 4 weeks then monthly thereafter as to the correction and maintenance of all deficient practices mentioned on Element #3 A & B. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of the inspection will be reported to the QA committee that meets quarterly for review, comment and recommendations	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for	K 363		5/2/25

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K 363	Continued From page 26 at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/6/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of	K 363	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The doors in rooms #538, #539, #540, #543, #544, #549, and #552 fixed and	

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K 363	Continued From page 27 NFPA 101: 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was identified for 7 of 37 resident rooms observed, had the potential to affect 50 residents and was evidenced by the following: Observations from 9:15 AM to 12:45 PM in the presence of the US FOIA (b)(6) revealed resident room doors did not operate properly as follows: - Room #538 - the door would not latch into its frame. - Room #539 - the door would not latch into its frame. - Room #540 - the door would not latch into its frame. - Room #543 - the door rubs into its frame. - Room #544 - the door rubs into its frame. - Room #549 - the door rubs into its frame. - Room #552 - the door would not close into its frame. In an interview at 12:00 PM, the US FOIA and the US FOIA (b)(6) confirmed the above findings. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/10/25 at 12:45 PM.	K 363	adjusted to resist the passage of smoke. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The Maintenance Director or his designee will conduct inspection of 10 doors weekly for the next 4 weeks then quarterly thereafter as to the integrity and adequate closure of all doors into its frames. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of this inspection will be reported to the QA committee quarterly for review, comment and recommendations	
K 753 SS=E	NJAC 8:39-31.1(c), 31.2(e) Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for	K 753		5/2/25

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K 753	Continued From page 28 product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/7/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to comply with the combustible decoration requirements of NFPA 2012-19.7.5.69(c) as evidenced by the following: 1). Observations at 11:52 PM on floor #1 by the business office revealed that the US FOIA (b)(6) [redacted] office door was fully covered in combustible paper decorations. 2). Observations at 12: 32 PM on floor #2 outside the Recreation office revealed that the closet in the exit corridor was fully covered in combustible paper decoration. The decoration paper covered 100-percent of the exterior side of each door, thus exceeding the maximum requirement of 30-percent. In an interview during the observations, the US FOIA [redacted] revealed that he was uncertain if the decorations were fire-retardant or treated with an approved fire-retardant chemical. The facility was unable to	K 753	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The combustible paper decorations in the DON's office door on floor #1 and likewise in the recreation door office on floor #2 were completely removed. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. All staff were given in-service about observance of code NFPA 2012-19.7.5.69(c). Return understanding	

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K 753	Continued From page 29 provide any additional documentation. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.2(e)	K 753	were obtained. The Maintenance Director and/or his designee will conduct inspection of ALL doors in the building for decorations posted on the wall, doors etc weekly for 4 months then quarterly thereafter. ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of these random audits will be reported to the QA committee who meets quarterly for review, comment and recommendations.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or	K 914		5/2/25

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K 914	Continued From page 30 area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 3/6/25 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to functionally test and identify electrical receptacles in residents' rooms that had non-hospital grade and hospital grade outlets annually for grounding, polarity, and blade tension in accordance with NFPA 99: 2012 Edition. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following. During record review, the surveyor reviewed the facility's electrical inspection report, dated 1/16/25, from the facility's licensed vendor. The report did not indicated that the rooms with non-hospital grade electrical outlets were annually inspected for grounding, polarity, and blade tension. In an interview at the time, the US FOIA [redacted] stated that many resident rooms had hospital grade and non-hospital grade outlets mixed together, but he did not provide complete documentation indicating the kind of outlets in each resident room. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 914	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Maintenance Director gave an in-service to all Maintenance staff to document in writing as they complete the annual functionally test to identify electrical receptacles in resident's room that has non-hospital grade and hospital grade outlets for grounding. The contracted vendor will be required annually to inspect the rooms with non-hospital grade electrical outlets for grounding, polarity and blade tension. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The Maintenance Director or his designee will randomly check 10 rooms weekly x4 weeks then quarterly thereafter to functionally test and identify electrical receptacles in resident's room for grounding, polarity and blade tension.	

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K 914	Continued From page 31	K 914	ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of this review audit will be reported to the QA committee who meets quarterly for review, comment and recommendations	
K 921 SS=E	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use	K 921		5/12/25

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K 921	Continued From page 32 of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 3/6/25 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that Inspection, Testing and Maintenance (ITM) intervals were established with policies and protocols for Patient Care Related Electrical Equipment (PCREE) in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1 and 10.3.5.4. This deficient practice was observed for 2 of 38 PCREE and was evidenced by the following: 1). Observations at 10:14 AM in resident room # NJ Ex Or reveals that the doorside resident bed was not provided with any annual documentation that patient care electrical equipment was inspected. It was observed that an orange modified electric plug was installed to the electrical cord and plugged into the duplex wall outlet. 2). Observations at 11:11 AM in resident room # NJ Exec O NJ Exec Order 26.4b resident) that a patient care NJ Exec Order 26.4b1 had a modified electric plug attached to the cord that was plugged into the duplex wall outlet. The US FOIA indicated the NJ Exec Order 26 was rented and the vendor may have modified the plug. In an interview during the observations, the US FOIA stated there was no complete ITM documentation for PCREE that included patient beds, air mattresses, oxygen concentrators, nebulizer and	K 921	ELEMENT 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The modified electric plugs of resident in room # NJ Ex Or and the NJ Ex Order 26.4(b)(1) of resident in room # NJ Ex Or were removed. ELEMENT 2 -How the facility will identify other residents having the potential to be affected by the deficient practice. All residents at the facility have the potential to be affected by this Life Safety Code citation. ELEMENT 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not occur. The Regional Corporate Maintenance Director gave an in-service to all maintenance staff that all PCREE must have complete ITM documentation annually. Return demonstration of understanding were obtained. The Maintenance Director and/or his designee will inspect 20 PCREE weekly for the next 4 weeks then monthly thereafter using a checklist tool to document findings.	

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K 921	Continued From page 33 similar items that were used for patient care. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 3/10/25 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	ELEMENT 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The results of these inspections will be reported to the QA committee who meets quarterly for review, comment and recommendations	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315344 Y1	A. Building B. Wing Y2	5/22/2025 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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0004	Correction	ID Prefix E0018	Correction	ID Prefix E0029	Correction
Reg. # 483.73(a)	Completed	Reg. # 483.73(b)(2)	Completed	Reg. # 483.73(c)	Completed
LSC	04/18/2025	LSC	04/30/2025	LSC	04/30/2025
ID Prefix E0041	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/20/2025	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	
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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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/10/2025	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315344 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/22/2025 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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0232	05/12/2025	LSC K0281	05/12/2025	LSC K0293	04/30/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	05/13/2025	LSC K0321	05/12/2025	LSC K0353	05/13/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	05/02/2025	LSC K0363	05/02/2025	LSC K0753	05/02/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0914	05/02/2025	LSC K0921	05/12/2025	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/10/2025	☐ YES ☐ NO