STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING _____ B. WING _____	C 01/13/2023

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

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E 000	Initial Comments This facility is 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		
F 000	INITIAL COMMENTS Standard Survey: 1/13/23 Census: 127 Sample Size: 37 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 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582		2/28/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/09/2023

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 582	Continued From page 1 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to issue the required Medicare Beneficiary Protection Notification for 1 of 3 residents	F 582	The following represents the Plan of Correction (POC) for the alleged deficiencies cited during a Recertification and State Licensure survey that was	

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F 582	Continued From page 2 (Resident #119) reviewed. This deficient practice was evidenced by: On 1/5/23 at 10:00 AM, the facility's Social Service Director (SSD) and Social Worker provided the surveyor with a list of residents who were discharged from the facility within 6 months and should have received Beneficiary Notices. The surveyor reviewed one of the residents, Resident #119 listed who was discharged from a Medicare Part A coverage stay at the facility and was documented as having a discontinuation of their insurance payment. Review of facility medical records showed that Resident #119 was admitted to the facility on EX Order 26 §. The last date documented for insurance coverage was from EX Order 26 § 4b1 , 10/28/22. A review of the form titled, "Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) and "Notice of Medicare Non-Coverage (NOMNC) dated 10/25/22 documented, "Family notified by phone" regarding the residents last insurance coverage date. Further review of the form revealed that it did not include the family member's identity. There was no additional documentation about the communication of these forms to the resident or the resident's representative. On 1/9/23 at 10:44 AM, the surveyor interviewed the SSD. The SSD stated that the SNFABN and NOMNC forms should be issued at least 48 hours before the resident's last covered date. The SSD explained that if a resident had a Brief	F 582	conducted and completed on January 13, 2023. The completion and execution of these POCs do not constitute an admission of wrong doing on the part of Alaris Health Castle Hill, its owners, operators, employees or agents or an agreement with any of the facts set forth in the Statement of Deficiencies. The POCs are completed in good faith and in keeping with the center's commitment to quality outcomes for the residents. In addition, these POCs are completed as required by law. _____ _____ _____ ____. Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #119 has a BIMs score of EX and EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order EX Order 26 § 4b1 48 hours prior to the termination EX Order 26 There was no direct personal contact from the residents' representative to obtain a signature nor a certified letter was sent. Howver, the conversation between the resident's representative and the Social Worker (SW) issuing the NOMNC was witnessed by another Social Worker. This same resident remains at	

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F 582	Continued From page 3 Interview for Mental Status (BIMS) score of less than EX Order 26 § 4b1 the service end date, possible cost, and right to appeal would be discussed with the resident's representative. The SSD added that Resident #119 had a BIMS [redacted] out of 15, which indicated that the resident had [redacted] The SSD stated that she notified the resident's daughter-in-law via phone on 10/25/22 to discuss the resident's last covered date of [redacted] and that the family member was not interested in paying for the therapy services. The SSD acknowledged that she did not have any electronic nor written documentation of the discussion on the SNFABN and NOMNC forms nor did she have the signed forms from the resident's representative. She stated that she was not aware that the forms were to be mailed to the resident's representative to be signed and returned to the facility. A review of facility policy and procedure titled, "Notice of Medicare Non-Coverage" with an original issue date of 1/10/23 indicated under "Policy: Alaris Health at Castle Hill will provide a written and verbal notices to the resident and/or responsible party to indicate that the care is set to end." The facility policy further indicated under, "Procedures: The resident's representative may receive and accept the written notice if the resident is unable to comprehend the notice being given. If the resident and/or representative are not available to receive the notice, a certified letter will be sent to the address listed on the face	F 582	the facility under Managed Long-Term Services and Supports (MLTSS), however resident #119 was recently transferred to the NJ Exec. 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 who are admitted to Alaris Health Castle Hill (AHCH) who are covered by Medicare and/or by the Medicaid State plan, 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. The Administrator revised the Policy and Procedure on the issuance of NOMNC to the resident or representative. All the SW and Admission Director were given an in-service education about the revision of the policy. A competency and return demonstration on the understanding of the newly revised policy were obtained. The IDCP (Interdisciplinary) Team will discuss during the Utilization Review (UR) residents that will be discharged; determine the date of discharge. 48 hours prior to the discharge date, the SW or her designee will issue a NOMNC letter. If a resident is alert and oriented, the NOMNC letter can be issued to the resident and obtained their signature. If a resident is unable to comprehend the content of the NOMNC letter (or his/her BIMs score<10),	

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F 582	Continued From page 4 sheet." The policy provided by the facility did not address SNFABN notification. A review of Requirements of the SNF ABN CMS-10055 Form, indicated under pages 41 and 49-50, "Obtain signed/dated SNF ABN with Option selected either in person (or return mail). Beneficiary retains patient copy-returns original. Telephone contacts should be followed immediately by either hand-delivered, mailed, emailed, or faxed notice. If beneficiary does not return signed copy, document initial contact and subsequent attempts to obtain signature in appropriate records or on notice itself." On 1/10/23 at 11:53 AM, the surveyor discussed the concern with the Director of Nursing and Licensed Nursing Home Administrator. No further information was provided. NJAC 8:39-4.1(a)(8)	F 582	a responsible party maybe given the NOMNC notice instead, sign and dated. If the notice is done telephonic process, a witness may counter-sign the conversation. A certified letter will be sent following the telephone conversation to obtain a signed receipt of NOMNC. 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 weekly all residents who are on Medicare Part A scheduled for discharge/discontinuation of insurance services to ensure that residents and/or representatives receives the appropriate and timely notices of NOMNC as per policy. This will be performed by the Administrator for the next 3 months. The results of the audit will be submitted to the Quality Assurance (QA) committee quarterly for the next quarter for review, comments or recommendations.	
F 655 SS=D	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.	F 655		2/28/23

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F 655	Continued From page 5 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. (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: Based on observation, interview and record review, it was determined that the facility failed to develop and implement a person-centered	F 655	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the	

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F 655	Continued From page 6 baseline care plan (CP) for facility residents within 48 hours of admission. This deficient practice was identified for 4 out of 28 residents reviewed, Resident #232, #83, #64 and #234 who had EX Order 26 § 4b1 [redacted] This deficient practice was evidenced as follows: 1. On 1/3/23 at 10:34 AM, during the initial tour, the 6th floor Licensed Practical Nurse/Unit Manager (LPN/UM6) informed the surveyor that one of the Spanish speaking residents on their unit was Resident #83. On 1/3/23 at 11:15 AM, the surveyor observed Resident #83 laying on the bed. The surveyor greeted the resident who responded in Spanish. On 1/3/23 at 11:20 AM, the surveyor interviewed the 6th floor Licensed Practical Nurse (LPN6) assigned to the resident who stated that Resident #83 speaks only Spanish. The LPN6 further stated that a translator and a communication board would be needed. The LPN6 with the aide of the surveyor, could not locate any communication board tool inside the resident's room. The surveyor reviewed Resident #83's medical record. Resident #83 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted], EX Order 26 § 4b1 EX Order 26 § 4b1. A review of the Admission Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care, dated 10/12/22. The MDS reflected that Resident #83 had a Brief	F 655	deficient practice. Both residents #83 and # 234 were discharged to [redacted] on [redacted]. Resident #232 now has a care plan for effective communication. Resident # 64 now has a care plan for management of NJ Exec. 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 who have [redacted] and also in need of communication assistance; likewise residents with residents with [redacted] EX Order 26 § 4b1 have the potential to be affected by these deficient practices. All residents admitted to Alaris Health Castle Hill (AHCH) require a baseline and comprehensive care plan, thus all can be potentially to be affected. Element 3 - What measures will be put into place or systemeic changes made to ensure that the deficient practice would not recur. A Baseline Care Plan will be developed for all new admissions and/or re-admissions within 48 hours of admission or re-admission. Social Workers (SW), MDS Coordinator and/or Unit Managers (UM) will identify residents who have lower BIMs score [redacted] or display NJ Exec. Order 26:4.b.1 and speaks/understands different language other than English.	

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F 655	Continued From page 7 Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating that they had a [redacted] The MDS assessment further reflected under "Section A1100, Language" that Resident #83 needed an interpreter and Spanish was their preferred language. A review of the resident's interdisciplinary person-centered comprehensive CP did not identify that the resident was Spanish speaking and required a communication board and an interpreter. 2. On 1/3/23 at 10:34 AM, during the initial tour, the LPN/UM6 informed the surveyor that one of the Spanish speaking residents on their unit was Resident #232. On 1/3/23 at 1:35 PM, the surveyor observed Resident #232 laying on the bed with eyes closed. The surveyor greeted the resident who responded in Spanish. The LPN6 assigned to the resident informed the surveyor that Resident #232 was [redacted], and could [redacted]. The surveyor reviewed Resident #232's medical record. Resident #232 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]. A review of the A/MDS, an assessment tool used to facilitate the management of care, dated 12/25/22 reflected that the resident had a BIMS score of [redacted] out of 15, indicating that the resident	F 655	The Registered Dietitian Eligible (RDE) will assess the residents upon their admission/re-admission on their nutritional status; develop a baseline and a comprehensive care plan for management of DM. The nutritional assessment will be reviewed by the Registered Dietitian (RD) and co-sign the assessment. A baseline and comprehensive cares plan will be created for all residents diagnosed with [redacted] Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing (DON) or her designee will audit all new admissions/re-admissions weekly those residents identified by the SW or UM who have the potential to be affected by the deficient practice for the next 3 months. The Administrator will review at least 5 residents/week for the next 3 months all residents diagnosed with [redacted] Results of all these audits will be submitted to the QA committee quarterly for comments and recommendations.	

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F 655	Continued From page 8 had a EX Order 26 § 4b1 . The assessment further reflected under "Section A1100, Language" that Resident #232 needed an interpreter and Spanish was their preferred language. Review of the A/MDS, "Section B1000 Vision", indicated "EX Order 26 § 4b1 ". A review of the resident's interdisciplinary person-centered comprehensive CP did not identify that the resident was Spanish speaking and NJ Exec. Order who required an interpreter. 3. On 1/3/23 at 2:00 PM, during the initial tour, Resident #234 was observed laying in bed with eyes closed. On 1/3/23 at 2:30 PM, the surveyor reviewed Resident #234's medical record. Resident #234 was admitted to the facility on NJ Exec. Order 26:4.b with diagnoses which included but were not limited to EX Order 26 § 4b1 to EX Order 26 § 4b1 and EX Order 26 § 4b1 . A review of the A/MDS, dated 12/28/22 reflected that the resident had a BIMS score of EX Or out of 15, indicating that the resident had a EX Order 26 § 4b1 The assessment further reflected under "Section A1100, Language" that Resident #234 needed an interpreter and Spanish as preferred language. Continued review of the A/MDS Under "Section B 1000 Vision", documented that the resident was "EX Order 26 § 4b1 ".	F 655		

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A review of the resident's interdisciplinary person-centered comprehensive CP did not identify that the resident was Spanish speaking and [NJ Exec. Ord] who required an interpreter.

On 1/5/23 at 2:00 PM, the survey team met with the facility's Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and RN/MDS Coordinator and discussed the above concerns. The LNHA, DON and RN/MDS Coordinator acknowledged that the above residents did not have a baseline CP implemented to address visual impairment and impaired communication/language barrier.

4. Resident #64 was admitted to the facility on [EX Order 26 § 4b1] with diagnosis including but not limited to EX Order 26 § 4b1

On 1/4/23 at 1:50 PM, during a review of the Annual MDS, an assessment tool used to facilitate the management of care, dated 12/2/2022, indicated that the resident had a BIMS score of [EX] out of 15, indicating that the resident had EX Order 26 § 4b1 .

Continued review of the Annual MDS, the assessment further reflected under Section I Active Diagnoses, that the resident has [EX Order 26 § 4b1]

A review of the electronic clinical physician orders (PO) for December 2022 presented an order with a start date of 3/31/22 for EX Order 26 § 4b1

Review of the PO demonstrated another order

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F 655	Continued From page 10 with a start date of 11/15/2022 for EX Order 26 § 4EX Order 26 § 4b1 [redacted] Continuing the review of the PO evidenced another order for a DM medication with a start date of 10/31/2019 for EX Order 26 § 4b1 [redacted] A review of the resident's interdisciplinary person-centered comprehensive CP with a revision date of 12/22/2022 evidenced that the resident did not include a baseline CP for the Diagnosis of EX Orde[redacted]. A review of the resident's electronic medical record under the vitals section reflected that resident's blood sugars were the following: EX Order 26 § 4b1 [redacted] On 1/5/23 at 11:04 AM, the surveyor interviewed	F 655		

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F 655	Continued From page 11	F 655		

the Licensed Practical Nurse (LPN4), who is the acting Unit manager for the fourth floor unit, who stated that Resident #64 should have a CP for [redacted] LPN #1 was unable to provide or explain why there was no CP for [redacted] created for Resident #64 since admission.

On 1/5/23 at 12:49 PM, the surveyor interviewed both LNHA and DON. During the interview the DON acknowledged that residents with a diagnosis of [redacted] should have [redacted]. The LNHA on the other hand indicated, "No, as long as those conditions are controlled like [redacted] or [redacted] but if they're uncontrolled there should be a CP."

The surveyor reviewed the documented blood sugars for the past five days on the Electronic Medical Record (eMAR) with the LNHA. The eMAR indicated eight instances of the [redacted]
When the surveyor shared this information with the LNHA, she acknowledged that Resident #64 should have a [redacted]. Neither DON or LNHA could provide any further information as to why this resident did not have a [redacted].

On 1/12/23 at 11:35 AM, the LNHA provided the surveyor with a policy titled, Person Centered Care Planning Policy & Procedures last revised on 1/11/23. The Policy Statements states, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."

Under Policy Interpretation and Implementation states;

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

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F 655	Continued From page 12 "2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment." "9. Areas of concern and medical Diagnosis/comorbidities that are identified during the resident assessment on admission and on an ongoing basis will be evaluated before interventions are added to the care plan." NJAC 8:39 - 27.1(a)	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 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	F 656		2/28/23

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F 656	Continued From page 13 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, and record review it was determined that the facility failed to develop and implement a comprehensive, person-centered care plan (CP) for residents in the facility. This deficient practice was identified for 3 of 28 residents reviewed for comprehensive care plans (Resident #122 and #7) who had EX Order 26 § 4b1 related to a language EX Order 26 § and (Resident #129) who had an advance directive and was evidenced by the following: 1. On 1/3/23 at 1:47 PM, the surveyor observed Resident #122 sitting in their EX Order 26 § 4b1 watching a Spanish T.V. show in the dayroom. The surveyor introduced herself to the resident who responded in Spanish. At around the same date and time, the surveyor	F 656	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Residents #122 and #7 comprehensive care plans have been revised to include a care plan on their need of communication tool. Resident #129 is no longer a resident at AHCH; NJ Exec. Order 26:4.b.1 on EX 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 at AHCH who have cognitive impairment and unable to communicate in English and require an interpreter have	

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F 656	Continued From page 14 interviewed the Licensed Practical Nurse/LPN and stated that Resident #122 speaks only Spanish. A review of Resident 122's medical record revealed the following: Resident #122 was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted]. The quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated 10/12/22 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating that the resident had a [redacted]. The QMDS assessment further reflected under "Section A1100, Language Spanish" was the resident's preferred language. This was an indication that Resident #122 needed/wanted an interpreter to communicate with a doctor or healthcare staff member. A review of Resident #122's CP did not include that the resident was Spanish speaking and he/she required an [redacted]. 2. On 1/3/23 at 2:06 PM, the surveyor observed Resident #7 sitting in her [redacted] in the dayroom for activities. The surveyor introduced herself to the resident who responded in Spanish. At around the same date and time, the surveyor interviewed the Recreation Aide who informed the surveyor that Resident #7 speaks only Spanish.	F 656	the potential to be affected. All residents who have not clearly established their health code status have the potential to be affected. Element 3 - What measures will be put into place or systemeic changes made to ensure that the defcient practice would not recur. The SW and UM will identify residents who are [redacted] with BIMS < [redacted] and unable to communicate in English and require an interpreter. A care plan will be put into place by the SW and/or UM to address the need for a communication tool. The Code Status of all residents at AHCH will be reviewed on admission by the SW or UM and immediately develop a comprehensive care plan to address this. The code status of the residents will be discussed and reviewed again during their annual, quarterly assessment by the INterdisciplinary Care Plan (IDCP) team or as the status changes at anytime of their stay at the facility. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or her designee will audit 5 charts/ weekly from the list of residents identified by the SW and/or UM who are potentially at risk for these deficient practices for the next 3 months. REsults	

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F 656	Continued From page 15 A review of Resident #7's medical record revealed the following: Resident #7 was admitted to the facility on [redacted] with diagnoses that included but not limited to [redacted]. The QMDS assessment dated 12/6/22, reflected that the resident had a BIMS score of [redacted] out of 15, indicating that the resident had [redacted]. The QMDS assessment further reflected under "Section A1100, Language Spanish" was the resident's preferred language. This was an indication that Resident #7 needed and wanted an interpreter to communicate with a doctor or healthcare staff member. A review of Resident #7's CP did not include that the resident was Spanish speaking, requiring an interpreter. A review of the facility policy titled "Person Centered Care Planning Policy & Procedures" with a revised date of 1/11/23 revealed the following under Policy Statement, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." The "Person Centered Care Planning Policy & Procedures" further indicated under Policy Interpretation and Implementation, "8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to	F 656	of the audit will be submitted to the QA committee quarterly for review, comments or recommendations.	

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attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; j. Reflect the resident's expressed wishes regarding care and treatment goals; 12. The comprehensive, person-centered care plan is developed within (7) days of the completion of the required comprehensive assessments (MDS)."

On 1/5/23 at 12:49 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and MDS Coordinator. The surveyor discussed the above concern with the administrative team. The DON acknowledged that the above residents did not have a comprehensive CP developed and implemented to address their impaired communication/language barrier. The administrative team acknowledged that a CP for impaired communication and language barrier should be initiated for all residents that are Spanish speaking.

On 1/6/23 at 9:32 AM, the DON and LNHA met with the survey team. The administrative team could not explain why there was no CP initiated and created for the residents reviewed. No further information was provided.

3. On 1/10/23 at 11:48 AM, the surveyor conducted a review of the hybrid medical record (electronic and paper) which indicated that Resident #129 was admitted to the facility on EX Order 26 § 4b1 and EX Order 26 § 4b1 in the facility on EX Order 26 § 4b1.

Review of Resident #129's Face Sheet (document that gives a patient's information at a quick glance) indicated that the resident's diagnosis included, but were not limited to: EX Order 26 § 4b1 .

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Further review of the resident's hybrid medical record revealed the New Jersey Practitioner EX Order 26 § 4b1 which was signed on 4/20/2022, indicating that the resident was listed as, EX Order 26 § 4b1 [redacted]

A review of the resident's Physician Orders revealed that the code status of Resident #129 had changed from [redacted] to EX Order 26 § 4b1 on 6/21/2022.

A review of the resident's last Interdisciplinary Team (IDT) meeting note conducted on 10/5/22 revealed under code status that the resident was a EX Order 26 § 4b1 .

A review of the resident's baseline care revealed that there was no CP created to reflect the code status of Resident #129.

On 1/11/23 at 11:24 AM, the surveyor conducted an interview with the DON and the LNHA. The LNHA stated that the code status of the resident should have its own CP, but neither the LHNA or DON could explain why the resident did not have any CP reflecting the code status. No further information was supplied to the surveyor regarding this issue.

On 1/12/23 at 11:35 AM, the LNHA provided the surveyor with the facility policy titled, "Person Centered Care Planning Policy & Procedures," which was last updated on 1/11/23. The Policy Statement states, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional

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F 656	Continued From page 18 needs is developed and implemented for each resident." Under Policy Interpretation and Implementation, it states. "7. The care planning process will a. Facilitate resident and/or representative involvement; b. Include an assessment of the resident's strengths and needs; and c. Incorporate the resident's personal and cultural preferences in developing the goals of care. 8. The comprehensive, person-centered care plan will: c. Describe services that would otherwise be provided for those the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change," NJAC 8:39-11.2 (e)(2)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657		2/28/23

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F 657	Continued From page 19 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to review and revise a care plan (CP) to reflect changes to a resident's NJ Exec. Order 26:4.b.1 for 2 of 28 residents (Resident #5 and #116) reviewed. The deficient practice was evidenced by the following: 1. On 1/3/23 at 10:30 AM, the surveyor observed Resident # 5 with eyes closed, laying on an EX Order 26 § 4b1 The resident was not able to be interviewed. A review of the Admission Record for Resident #5 revealed that the resident was last admitted to the facility on NJ Exec. Order 26:4 with diagnoses that included but were not limited to: EX Order 26 § 4b1 A review of a Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the	F 657	lement 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The comprehensive care plans of Residents #5 and #116 were reviewed and updated to reflect the changes in resident's NJ Exec. Order 26:4.b.1 plan. Resident #5 now have an order and is receiving EX Order 26 § 4b1 Resident #116 is now receiving NJ Exec. Order 26:4 care plan has been updated to reflect to current order. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. Other residents who are on NJ Exec. Order 26 and	

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management of care, dated 12/6/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident had [redacted].

The MDS further indicated that the resident had a [redacted]

A review of the resident's dietary CP dated from 12/15/22 to 12/21/22, revealed under the Focus section that the resident had a potential for altered nutrition related to [redacted] Further review of the CP identified under the Interventions section, "Provide supplements as ordered: [redacted]

A review of resident's Electronic Medical Record under the Physician's Order for January 2023, revealed the resident did not have an order for the supplement [redacted]

On 1/5/23 at 10:31 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the resident was not currently receiving [redacted]. The LPN explained that the [redacted] was ordered for the resident on 8/24/22 and was discontinued on 9/23/22 per the electronic medical record. The LPN indicated that the dietary CP had not been updated to show the discontinuation of the [redacted].

2. On 1/3/23 at 10:30 AM, the surveyor observed Resident #116 in bed with eyes closed. The resident's breakfast tray was at bedside, partially eaten. The tray ticket indicated that the resident is

NJ Exec. Order 26:4.b.1 for [redacted]; residents who requires modifications with NJ Exec. Order 26:4.b.1 have the potential to be affected by these deficient practice.

Element 3 - What measures will be put into place or systemic changes made to ensure that the defcient practice would not recur.

The Dietitian will review all residents who requires NJ Exec. Order 26:4.b.1 supplements and ensure that an order is current and are reflected in their comprehensive care plan.

The Dietitian or her designee will review all diet orders of the residents and ensure that current and appropriate diet orders are also reflected in their comprehensive care plan.

Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

The DON or designee will audit 5 charts/week for the next 3 months of those residents who require [redacted] for NJ Exec. Order 26:4.b.1 are ordered and are reflected in their care plan. Likewise, additional 5 charts/week will be reviewed for the next 3 months by the Dietitian and/or designee to check on the appropriateness of diet order and are reflected in the care plan. Results of these audits will be submitted to the QA

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F 657	Continued From page 21 on a [NJ Exec. Order 26:4.b.1] diet consistency. A [NJ Exec. Order 26:4.b.1] food diet refers to using equipment, such as a [NJ Exec. Order 26:4.b.1] to create foods that need [NJ Exec. Order 26 4.b.1]. A review of the Admission Record for Resident #116 revealed that they were initially admitted to the facility on [NJ Exec. Order 26:4] with diagnoses that included but were not limited to: [EX Order 26 § 4b1] A review of Resident #116's Electronic Medical Record under the Physician's Order for January 2023 revealed the resident had a diet order for '[EX Order 26 § 4b1] A review of the resident's dietary CP dated from 9/16/22 to 12/27/22, revealed under the Focus section that the resident, [NJ Exec. Order 26:4.b.1] : [EX Order 26 § 4EX Order], no A [EX Order 26 § 4b1] is defined as foods that require [EX Or][EX Order 26 § 4b1] On 1/6/23 at 9:32 AM, the surveyor interviewed the Director of Nursing (DON) and Licensed Nursing home Administrator (LNHA). The LNHA stated that the dietary CP should be updated by the dietitians but neither the LHNA nor the DON could explain why the CP had not been updated for Resident #116. On 1/9/23 at 10:15 AM, the surveyor conducted a phone interview with the Registered Dietitian (RD). The RD could not explain why the resident's CP had not been updated. The RD acknowledged that it would be their responsibility	F 657	committee quarterly for review, comments and recommendations.	

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F 657	Continued From page 22 to update a resident's CP. On 1/11/23 at 11:55 AM, the surveyor met with the LNHA and DON to further discuss the CP discrepancy. No further information was provided. On 1/12/23 at 11:30 AM, the LNHA provided the surveyor with a policy titled, "Person Centered Care Planning Policy & Procedure," which was last revised on 12/21/21. Review of the policy revealed, "13. Assessments of residents are ongoing and care plans are revised as information about the resident and resident's condition change."	F 657		
F 658 SS=D	NJAC 8:39-27.1(a) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to administer, and appropriately document resident's physician ordered medications. This deficient practice was identified for 3 of 5 residents reviewed and observed during medication administration, Resident #34, #109 and Resident #11. This deficient practice was evidenced by the	F 658	lement 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #34 is now receiving EX Order 26 § [redacted] Resident #109 continous to receive EX Order 26 § 4b1 [redacted] Resident #109 also	2/28/23

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F 658	Continued From page 23 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 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." 1. On 1/5/23 at 8:14 AM, the State Surveyor along with the Federal Surveyor observed a Licensed Practical Nurse (LPN) on the 4th floor preparing for medication administration to Resident #34. The LPN signed the the electronic medication administration record (eMAR), documenting the administration of an [redacted] without administering this [redacted] to Resident #34 in the presence of the surveyors.	F 658	continous to receive [redacted] with [redacted] as ordered by MD. The [redacted] for resident #11. Resident was instructed to ask the nurse to remove the [redacted] from [redacted] when [redacted] ready. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who have an order for [redacted] have the potential to be affected. Element 3 - What measures will be put into place or systemeic changes made to ensure that the defcient practice would not recur. All Licensed Nurses were given in-service education by the DON and the Pharmacy Consultant about the administartion of NJ Exec. Order 26:4.b.1 as ordered by the MD. Likewise, an overall education was given by the DON or her designee on medication administration and documentation and signing on the Emar. A return competency and understanding about the teachings were obtained from the nurses. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or her designee and the	

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

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F 658	Continued From page 24 When the LPN completed the medication administration for Resident #34, the LPN explained that she administered the [EX Orde] [EX Order 2] to the resident "this morning" but did not sign for it in the eMAR. The State Surveyor requested the LPN to verify the [NJ Exec. Order 26:4.b] medication administered to Resident #34. At that point the LPN could not locate the [NJ Exec. Order 26:4.b] medication in the her medication cart. The LPN stated, "I used the last one earlier today." Review of the January 2023 eMAR revealed an order for [EX Order 26] [EX Order 26 § 4b] [EX Orde] [EX Order 26 §] with directions of EX Order 26 § 4b1 [redacted]. The start date for this physician's order (PO) was 9/26/22. On 1/5/23 at 11:46 AM, the State Surveyor called the Provider Pharmacy and spoke with the Registered Pharmacist (RPh) who indicated that a month's supply of EX Order 26 § 4b1 [redacted] r Resident #34 on 9/26/22, 10/23/22, 11/20/22, and 12/16/22. The RPh stated that Resident #34 should still have medication left until the end of January 2023. 2. On 1/5/23 at 8:25 AM, the State Surveyor along with the Federal Surveyor observed the LPN on the 4th floor preparing for medication administration to Resident #109. The LPN was observed signing for another medication in the eMAR, indicating administration of the medication prior to the preparation of medication to be administered to Resident #109. The LPN explained that she was signing for another [EX Orde] [redacted] previously administered in the morning to	F 658	Pharmacy consultant will conduct random medication pass on at least 10 medications pass/week for the next 3 months. Results of the audits will be submitted to the QA committee monthly for review, comment and/or recommendations.	

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F 658	Continued From page 25 Resident #109. This [redacted] was not administering to Resident #109 in the presence of the surveyors. The surveyor reviewed the eMAR and noted that the LPN signed for in the eMAR was not an [redacted] but rather [redacted] The surveyors did not observe the LPN administer the [redacted] to Resident #109. The LPN could not explain why she signed for the [redacted] without administering the medication to Resident #109. Review of the eMAR revealed an order for [redacted] as a supplement, documented as administered at the time of the observation. 3. On 1/5/23 at 8:39 AM, the State Surveyor along with the Federal Surveyor observed the 5th floor Registered Nurse (RN) approach Resident #11 to [redacted] that were documented as placed on the resident during the night shift. The RN noted that the [redacted] were not on Resident #11. Resident #11 informed the RN in Spanish, that she removed the [redacted] and threw them in the garbage this morning. The surveyors observed the RN sign off on the eMAR, documenting that she removed the [redacted]. The State Surveyor reviewed the January 2023 eMAR and noted 2 PO orders for [redacted]	F 658		

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F 658	Continued From page 26 EX Order 26 § 4b1 [redacted] The State Surveyor noted that the eMAR was signed as removed by the RN on 1/5/23, at the time of the surveyors observation. On 1/5/23 at 11:15 AM, the surveyor interviewed the RN who indicated that she signed for removing the EX Order 26 § 4b1, which she did not remove. The RN explained that she should have documented that she did not remove the [redacted] and added a note to explain that the resident had removed it prior. Review of the Medication Administration Policy and Procedure revised on 11/16/22 documents, "12. The nurse administering the medication must electronically sign, date and time the resident's eMAR by selecting "Y" (yes) after giving each medication. The nurse will then select the "Save" button to finalize the administration of given medications before moving to the next resident. 15. If a medication is withheld or refused, the individual administering the medication shall select "N" (no) on the eMAR followed by selecting the appropriate reasoning and documentation. The nurse will then select the "Save" button to finalize the documentation." On 1/5/23 at 2:15 PM, the surveyor informed the Director of Nursing (DON), Licensed Nursing Administrator and Assistant DON of the deficient practice observed. No further information was provided. NJAC 8:39-11.2 (b); 29.2 (d)	F 658		
F 661 SS=E	Discharge Summary	F 661		2/28/23

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F 661	Continued From page 27 CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical records and other facility documentation, it was determined that the attending physician failed to document a discharge summary which included a recapitulation (recap) of the resident's stay and a final summary of the resident's status for 3 of 3 closed record's reviewed for discharge	F 661	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #128 and 130 were discharged from the facility. Their primary medical	

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F 661	Continued From page 28 to community, expiration, and discharge to the hospital (Resident #128, #129, and #130). This deficient practice was evidenced by the following: 1. On 1/10/23 at 11:40 AM, the surveyor reviewed the closed medical record for Resident #130. The closed record revealed that the resident was admitted to the facility on [redacted] and was discharged home on [redacted]. Further review of the medical record revealed that the Medical section of the discharge summary was not completed by the resident's physician but by the Minimum Data Set (MDS) Coordinator. 2. On 1/10/23 at 11:48 AM, the surveyor reviewed the closed medical record for Resident #129. The closed record revealed that the resident was admitted to the facility on [redacted] and had expired in the facility on [redacted]. Further review of the medical record revealed that the Medical section of the discharge summary was not completed by the resident's physician but by the MDS Coordinator. 3. On 1/10/23 at 12:01 PM, the surveyor reviewed the closed medical record for Resident #128. The closed record revealed that the resident was admitted to the facility on [redacted] and was discharged to the hospital on [redacted]. Further review of the medical record revealed that the Medical section of the discharge summary was not completed by the resident's physician but by the MDS Coordinator. On 1/12/23 at 1:24 PM, the surveyor conducted an interview with the Licensed Nursing Home Administrator (LNHA), who stated that the	F 661	physicians reviewed and completed their discharge summaries. Resident #129 [redacted] on [redacted]. A recapitulation of residents' stay at the facility were reviewed and documented in the discharge summary by the IDCP team and MD. 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 or with plans to be discharge have the potential to be affected by the deficient practice. Element 3 - What measures will be put into place or systemeic changes made to ensure that the defcient practice would not recur. All IDCP team were given an in-service by the Facility Educator about the completion of discharge summaries within 30 days of residents who were discharged from the facility including those who [redacted] The Administrator sent a letter on 01/25/2023 to all credentialed physicians of the facility notifying them of the need to complete and sign all the discharge summaries of their residents. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Medical Record clerk will check and	

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F 661	Continued From page 29 medical section of the discharge summary should be filled out by the doctor but could not explain why that section had been completed by the MDS Coordinator. On 1/12/23 at 1:32 PM, the surveyor interviewed the MDS Coordinator who has been working in this facility role for three years. The MDS Coordinator stated, they were told to fill out the medical section of the discharge summary by the Director of Nursing (DON). The MDS Coordinator added that they have not been in communication with the physician but only reading the physician's notes when filling out the medical section of the discharge summary. The MDS Coordinator stated that they were not aware that the physician was supposed to complete the medical section of the discharge summary. On 1/12/23 at 1:54 PM, the surveyor interviewed the DON, who stated that the previous Assistant Director of Nursing (ADON) filled out the Medical section of the discharge summary, but had recently asked the MDS Coordinator to complete the medical section of the discharge summary. The DON stated that she was not aware that the physician was responsible for filling out the medical section of the discharge summary. On 1/12/23 at 1:00 PM, the LNHA provided the surveyor with a policy titled, "Policy/Procedure - Discharge Summary", dated, reviewed and signed by the LNHA on 1/12/23. Under the Intent section, the policy states, "It is the policy of the facility to assure that a discharge summary is completed in accordance to the State and Federal requirements." The "Procedure section," states: "2. When the facility anticipates discharge, a	F 661	audit all discharged and expired residents' charts weekly for completion and signature. This will be an on-going process by the Medical Record Clerk. Results of the weekly audits of all charts of the residents discharged from the facility will be submitted to the DON or designee monthly as an on-going QAPI program for completeness. The DON or designee will submit the results to the QA committee quarterly for the next 4 quarters for review, comments and recommendations.	

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F 661	Continued From page 30 resident must have a discharge summary that includes, but is not limited to, the following: a. A recapitulation of the resident's stay that includes, but is not limited to, diagnosis, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. b. A final summary of the resident's status to include items in paragraph (b) (1) of 483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. c. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over the counter)." N.J.A.C. 8:39-35.2(d)(16)	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the 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 diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in	F 676		2/28/23

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F 676	Continued From page 31 accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide a communication device for a resident identified as having a language barrier. This deficient practice was identified for Resident #83, 1 of 4 residents reviewed for language and communication and was evidenced by the following: 1. On 1/3/23 at 10:34 AM, during the initial tour, the surveyor was informed by the Licensed Practical Nurse/Unit Manager (LPN/UM) that one of the Spanish speaking residents on their unit was Resident #83. On 1/3/23 at 11:15 AM, the surveyor observed Resident #83 laying on the bed. The surveyor introduced self to the resident who responded in Spanish.	F 676	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #83 is no longer at the facility. [redacted] was discharged to [redacted] on [redacted] Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who speak or understand different language other than English has the potential to be affected by this deficient practice. Initial assessments of the resident done by the either the SW, MDS Coord. and/or UM will be utilized to identify residents who have language	

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F 676	Continued From page 32 On 1/3/23 at 11:20 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to the resident who stated that Resident #83 speaks only Spanish. The LPN further stated that a translator and a communication board would be needed. The surveyor could not locate any communication board tool inside the resident's room. The LPN acknowledged that there was no communication board inside the resident's room. The surveyor reviewed Resident #83's medical record. Resident #83 was admitted to the facility on [NJ Exec. Order 26] with diagnoses which included but were not limited to [EX Order 26 § 4b1] [redacted]. A review of the Admission Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care, dated 10/12/22 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [EX O] out of 15, indicating that the resident had [EX Order 26 § 4b1] [redacted]. The assessment further reflected under "Section A1100, Language" that Resident #83 needed an interpreter and "Spanish" as the preferred language. On 1/5/23 at 2:00 PM, the above concern was discussed with the facility's Licensed Nursing Home Administrator and DON who did not provide any further information and could not explain why Resident #83 did not have a communication board available in the resident's room. NJAC 8:39-27.1 (a)	F 676	barrier and will need communication tools. Element 3 - What measures will be put into place or systemeic changes made to ensure that the defcient practice would not recur. Social Worker (SW),MDS Coord, Unit Manager (UM) and other direct care staff will be educated by the DON or designee to identify residents who speak and/or understand different language other than English and will need a communication device. SW and/or UM will develop a baseline and/or comprehensive care plan to address this issue. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or designee will conduct an audit on 5 residents weekly for the next 3 months from the list identified by the SW/UM and/or MDS Coord to be in need of a communication devise and if implemented. Results of the audit will be submitted to the QA committee quarterly for the next 4 quarters for comments and recommendations.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		2/28/23

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F 695	Continued From page 33 CFR(s): 483.25(i) § 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: Based on observation, interview, and record review, it was determined that the facility failed to ensure that the EX Order 26 § 4b1 was administered to a resident in accordance with the current physician's orders (PO). This deficient practice was observed for 1 of 4 residents (Resident #56) reviewed for EX Order 26 § 4b1. This deficient practice was evidenced by the following: On 1/3/23 at 1:26 PM, the surveyor observed Resident #56 laying in bed with EX Order 26 § 4b1 in use via a EX Order 26 § 4b1 EX Order 26 § 4b1 On 1/5/23 at 10:57 AM, the surveyor observed Resident #56 laying in bed with EX Order 26 § 4b1 EX Order 26 § 4b1 concentrator. On 1/6/23 at 10:27 AM, the surveyor observed Resident #56 laying in bed with EX Order 26 § 4b1 EX Order 26 § 4b1	F 695	lement 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #56 remains to be resident at Alaris Health at Castle Hill (AHCH). This same resident now receives EX Order 26 § 4b1 Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents who have an order for EX Order 26 § 4b1 have the potential to be affected by the deficient practice. Element 3 - What measures will be put into place or systemeic changes made to by the deficient ensure that the defcient practice would not recur.	

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F 695	Continued From page 34 The surveyor reviewed Resident #56's medical records which revealed the following: The Admission Record revealed that Resident #56 was admitted to the facility with diagnosis that included but was not limited to EX Order 26 § 4b EX Order 26 § 4b1 [redacted]. The Quarterly Minimum Data Set dated 11/30/22, an assessment tool used to facilitate care management, revealed a Brief Mental Status (BIMS) score of [redacted] out of 15 indicating that the resident had a EX Order 26 § 4b1 . The January 2023 Order Summary Report revealed that there was a PO with a start date of 8/11/22 for EX Order 26 § 4b1 [redacted]. On 1/6/23 at 10:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN stated that Resident #56 was on [redacted] at [redacted] as needed for NJ Exec. Order 26:4.b.1. The surveyor brought the LPN to Resident #56's room to check the [redacted] that was administered to the resident. The LPN identified that the rate on the [redacted] concentrator for Resident #56 was set at [redacted]. The LPN reviewed the PO and acknowledged that the PO was for the [redacted] to be administered at EX Order 26 § 4b1 [redacted]. A review of the facility policy titled "EX Order 26 § 4b1 [redacted]" with a revised date of 7/1/22 under "EX Order 26 § 4b1 [redacted].	F 695	All licensed nursing staff were given an in-service about the use of [redacted] and following to what is ordered by MD. All UM will identify residents who requires NJ Exec. Order 26:4.b.1, review MD's order and verify what is actually being administered to the resident. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. 5 random audits/week for the next 3 months will be conducted by the DON or designee to check the MD's order and what is being given to the resident. Results of the audit will be submitted to the QA committee during quarterly meeting for comments or recommendations.	

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F 695	Continued From page 35 On 1/9/23 AT 2:10 PM, the surveyor expressed her concern to the Licensed Home Administrator (LNHA) and Director of Nursing. The LNHA agreed that the [redacted] should have been administered in the right setting and that the nurses were expected to follow the physician's order. No further information was provided to explain why the [redacted]. NJAC 8.39-29.2 (d)	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		2/28/23

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F 757	Continued From page 36 Based on observation, interview, and record review, it was determined that the facility failed to provide adequate indications and documentation supporting the rationale for blood sugar monitoring checks performed at 3 AM for a resident with a diagnosis of EX Order 26 § 4b1 NJ Exec. O). This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #27) and was evidenced by the following: On 1/4/23 at 2:00 PM, the surveyor observed Resident #27 seated in a EX Order 26 § 4b1 [redacted] A review of the resident's face sheet (an admission summary) reflected that Resident #27 was admitted to the facility on EX Order 26 § 4b with diagnoses that included but were not limited to EX Order 26 § 4b1 [redacted]. According to the Minimum Data Set, an assessment tool used to facilitate management of care dated, 12/8/22, Resident #27 was documented as having a Brief Interview for Mental Status score of [redacted] out of 15, indicating that the resident had a EX Order 26 § 4b1 [redacted]. A review of the January 2023 Electronic Medication Administration Report (eMAR) revealed a physician's order (PO) dated 12/30/22 for "EX Order 26 § 4b1 EX Order 26 § 4b1 [redacted] NJ Exec. Order 26:4.b.1 [redacted]	F 757	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #27 is no longer a resident at the facility. NJ Exec. Or was discharged to NJ Exec. Orde on EX Order 26 § 4b. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents who require NJ Exec. Orde [redacted] the potential to be affected. Element 3 - What measures will be put into place or systemeic changes made to ensure that the defcient practice would not recur. All Unit Managers (UM) will identify other residents who are on NJ Exec. Order 26 4.b.1 [redacted] order. The orders for NJ Exec. Orde [redacted] be reviewed by the DON or designee for its frequency and relevance, then discuss with the primary MD for recommendation or discontinuance. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or her designee will conduct at least 5 chart audit/week for the next 3 months from the list of residents identified	

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F 757	Continued From page 37 Further review of the January 2023 eMAR presented another physician order dated 12/3/22 for "EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 [redacted] On 1/13/23 at 11:02 AM, the surveyor interviewed the Nurse Practitioner (NP) taking care of Resident #27. The surveyor asked the NP for the rationale regarding the PO scheduled for 3:00 AM to check the EX Order 26 § 4b1 l of the resident when there was another EX Order 26 § 4b1 scheduled at EX Order 26 § 4b1 and EX Order 26 § 4b1 EX Order 26 § 4b1. The NP responded, "checking the NJ Exec [redacted] at or around that time of the day will result in the most accurate level due to EX Order 26 § 4b1 [redacted]" When requested, the NP could not provide any documented rationale evidencing the need for the EX Order 26 § 4b1 . On 1/13/22 at 2:00 PM, the above concerns were discussed with the facility's Licensed Nursing Home Administrator and the Director of Nursing who did not provide any further information documenting the rationale for a NJ Exec. Order 26:4.b.1 [redacted] order. NJAC 8:39-29.2 (d)	F 757	to have an order for NJ Exec. Order 26 4.b.1 [redacted] The results of the audits will be submitted to the QA committee quarterly for comments and recommendations.	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759		2/28/23

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F 759	Continued From page 38 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a medication rate error below 5%. The surveyor observed 4 nurses administer 28 doses of medication to 5 residents and there were 2 errors which resulted in a medication error rate of 7.14 %. The deficient practice was evidenced by the following: 1. On 1/5/22 at 8:14 AM, during the medication administration observation (medpass), the State Surveyor along with the Federal Surveyor observed the Licensed Practical Nurse (LPN) #1 preparing to administer medications to Resident #34 which included a Physician's order (PO) for EX Order 26 § 4b1 LPN#1 stated that the EX Order 26 § 4b1 was unavailable. LPN#1 proceeded to administer EX Order 26 § 4b1 d that she felt she had to give something to Resident #34 for EX Order 26 § 4b1. During an interview right after medpass to Resident #34 with LPN#1, LPN#1 indicated that the physician gave her the right to substitute EX Order 26 § 4b1. LPN#1 could not produce any documentation referring to the physician's order for EX Order 26 § 4b1. 2. On 1/5/22 at 9:11 AM, during the med pass,	F 759	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #34 was assessed by the DON on 01/05/2023 for any adverse effect of EX Order 26 § 4b1. The Physicin for resident #34 was notified by the DON on 01/05/23 of the medication error on 1/05/2023, order received to continue with EX Order 26 § 4b1 LPN #1 was provided 1:1 Medication Pass In-service by the DON, LPN#1 was able to demonstrate competency for Medication Pass on 1/06/2023. Resident #107 was assessed by the DON on 1/05/2023 for any adverse effect of receiving the EX Order 26 § 4b1; there was no adverse side effect noted. The the DON notified the physician for resident #107 of the medication error. The physician ordered to continue with the current medication EX Order 26 § 4b1. LPN #2 was provided 1:1 Medication Pass In-Service by the DON, LPN #2 demonstrated understanding and	

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F 759	Continued From page 39 the surveyor observed LPN#2 preparing to administer medications to Resident #107 which included a PO for NJ Exec. Order 26:4.b.1 tablet daily as a supplement. LPN#2 was observed preparing and administering NJ Exec. Order 26:4 [redacted] to Resident #107. During an interview with LPN#2, he informed the surveyor that he did not have any NJ Exec. Order 26:4 [redacted] tablets available in his medication cart. Review of the Medication Administration Policy and Procedure, documented, "3. Medications must be administered in accordance with the orders, including any required time frame" and "6. The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication." On 1/5/22 at 2:00 PM, the surveyor brought these findings to the Licensed Nursing Home Administrator, the Director of Nursing (DON) and the Assistant DON. There was no further information provided. NJAC 8:39-29.2 (d)	F 759	competency for Medication Pass on 1/6/2023 Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. Other residents receiving these medications have the potential to be affected by these deficiencies. Element 3 - What measures will be put into place or systemeic changes made to ensure that the defcient practice would not recur. All licensed nurses were given an in-service education by the DON or her designee about medication administration, ordering, substitution and delivery. The pharmacy consultant will conduct random medication pass observation on 4 nurses/month for the next 3 mos. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The pharmacy consultant will conduct random medication pass observation on 4 nurses/month for the next 3 months. Results of the audit will be submitted and reviewed by the QA committee quarterly for comments and recommendations.	
F 801 SS=E	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2)	F 801		2/28/23

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F 801	Continued From page 40 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to	F 801		

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F 801	Continued From page 41	F 801		

November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.

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F 801	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of electronic medical records, it was determined that the facility failed to ensure that a fully Registered Dietitian sign/co-sign the nutrition assessment and nutrition re-assessments for 11 of 16 residents, Resident #286, #95, #59, #283, #284, #114, #287, #282, #93, #285 and #128. This deficient practice was evidence e by the following: (Rev. 207; Issued: 09-30-22; Effective: 09-30-22; Implementation: 10-01-22) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a) (1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (I) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in	F 801	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Nutritional assessments completed by the Registered Dietitian Eligible (RDE) for Resident #286, #95, #59, #283, #284, #114, #287, #282, #93, #285, and #128 were reviewed and co-signed by a Registered Dietitian. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents that require the nutritional assessment to be completed will have the potential to be affected by this deficient practice. Element 3 - What measures will be put into place or systemeic changes made to ensure that the defcient practice would not recur. The Administrator, who is also a Registered Dietitian will review and co-sign daily or as needed all nutritional assessments completed by the RDE. The current RDE employed by the facility will obtain her eligibility exam in March, 2023. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

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F 801	Continued From page 43 which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization or meets the requirements of paragraphs (a)(1)(I) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016, or as required by state law On 1/6/23 at 10:14 AM, the surveyor interviewed the Registered Dietitian Eligible, (RDE) employed by the facility. The term Registered Dietitian Eligible is used by the Commission on Dietetic Registration (CDR) to identify individuals who have met didactic and supervised practice requirements and have established eligibility to take the registration examination. During the interview, the RDE informed the facility that they were employed by the facility as of December 13, 2022. The RDE explained that she had recently finished her Dietetic internship but had not yet taken the Registered Dietitian (RD) exam. The RDE verified that the facility did not have a RD in the building but had an RD who worked remotely. The RDE established that she had not been trained nor met the RD in person. The RDE explained that the basis of their communication was either text messaging or electronic mail. The RDE revealed that the RD does not sign any of her notes. 1. On 1/6/23 at 10:30 AM, the surveyor was reviewing the Electronic Medical Chart (EMC) for Resident #286. Resident #286 was admitted to	F 801	The Administrator will randomly review 5 charts/ week for the next 12 weeks to ensure that all nutritional assessments completed by the RDE are co-signed by RD until the RDE obtains her eligibility RD license. The results of the audit will be submitted to the QA committee quarterly for review, comment and recommendations.	

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F 801	Continued From page 44 the facility on EX Order 26 § 4b1 with diagnosis that included but were not limited to EX Order 26 § 4b1 EX Order 26 § 4b1 . During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/28/22 and there was no evidence of an RD co-signing the information documented by the RDE. 2. On 1/6/23 at 10:35 AM, the surveyor was reviewing the EMC for Resident #95. Resident #95 was admitted to the facility on NJ Exec. Order 26 4.b.1 with diagnosis that included but were not limited to EX Order 26 § 4b1 . During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 1/4/22 and there was no evidence of an RD co-signing the information documented by the RDE. 3. On 1/6/23 at 10:40 AM, the surveyor was reviewing the EMC for Resident #59. Resident #59 was admitted to the facility on NJ Exec. Order 26 4.b.1 with diagnosis that included but were not limited to EX Order 26 § 4b1 During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/22/22 and there was no evidence of an RD co-signing the information documented by the RDE. 4. On 1/6/23 at 10:45 AM, the surveyor was	F 801		

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F 801	Continued From page 45 reviewing the EMC for Resident #283. Resident #283 was admitted to the facility on [NJ Exec. Order 26:4.b.1] with diagnosis that included but were not limited to EX Order 26 § 4b1 [redacted]. During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/21/22 and there was no evidence of an RD co-signing the information documented by the RDE. 5. On 1/6/23 at 10:50 AM, the surveyor was reviewing the EMC for Resident #284. Resident #284 was admitted to the facility on [NJ Exec. Order 26 4.b.1] with diagnosis that included but were not limited to EX Order 26 § 4b1 [redacted]. During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/21/22 and there was no evidence of an RD co-signing the information documented by the RDE. 6. On 1/6/23 at 11:00 AM, the surveyor was reviewing the EMC for Resident #114. Resident #114 was admitted to the facility on [NJ Exec. Order 26 4.b.1] with diagnosis that included but were not limited to EX Order 26 § 4b1 [redacted]. During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/19/22 and there was no evidence of an RD co-signing the information documented by the RDE.	F 801		

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7. On 1/6/23 at 11:05 AM, the surveyor was reviewing the EMC for Resident #287. Resident #287 was admitted to the facility on EX Order 26 § 4b1 with diagnosis that included but were not limited to EX Order 26 § 4b1 EX Order 26 § 4b1 EX Order 26 § 4b1

During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/28/22 and there was no evidence of an RD co-signing the information documented by the RDE.

8. On 1/6/23 at 11:10 AM, the surveyor was reviewing the EMC for Resident #282. Resident #282 was admitted to the facility on EX Order 26 § 4b1 and resubmitted on EX Order 26 § 4b1 with diagnosis that included but were not limited to EX Order 26 § 4b1 EX Order

During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/22/22 and the re-admission nutrition note on 1/5/23. There was no evidence of an RD co-signing the information documented by the RDE for both dates.

9. On 1/6/23 at 11:15 AM, the surveyor was reviewing the EMC for Resident #93. Resident #93 was admitted to the facility on NJ Exec. Order 26 4.b.1 with diagnosis that included but were not limited to EX Order 26 § 4b1 EX Order 26 § 4b1

During the review of the EMC what part, it was

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noted that the RDE completed the Initial Nutrition Note on 12/21/22 and there was no evidence of an RD co-signing the information documented by the RDE.

10. On 1/6/23 at 11:20 AM, the surveyor was reviewing the EMC for Resident #285. Resident #285 was admitted to the facility on EX Order 26 § 4b1 with diagnosis that included but were not limited to EX Order 26 § 4b1

During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/22/22 and there was no evidence of an RD co-signing the information documented by the RDE.

11. On 1/6/23 at 11:25 AM, the surveyor was reviewing the EMC for Resident #128. Resident #128 was admitted to the facility on EX Order 26 § 4b1 with diagnosis that included but were not limited to EX Order 26 § 4b1

During the review of the EMC what part, it was noted that the RDE completed the Initial Nutrition Note on 12/21/22 and there was no evidence of an RD co-signing the information documented by the RDE.

On 1/6/23 at 12:53 PM, the Surveyor conducted an interview with the Director of nursing (DON) and Licensed Nursing Home Administrator (LNHA). The LNHA informed the surveyor that there are two dietitians on staff at the facility. The LNHA explained that one is an RDE, who will be taking their accreditation test in March, and another dietitian who is a RD works remotely.

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F 801	Continued From page 48 The LNHA explained, "they are aware of the regulation and assumed that the RD was cosigning the RDE's notes." The LNHA revealed that she is a RD. Neither the LNHA nor the DON could explain why the RDE's notes were not being cosigned and no further information was provided. NJAC 8:39-17.1	F 801		
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or	F 836		2/28/23

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F 836	Continued From page 49 disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in facility name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following	F 836	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. There are no residents affected by this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. No other residents were identified to be affected by this citation. Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The Administrator at Optimacare Castle Hill received a letter from the NJ Department of Health on 2/21/2023 certifying the transfer of ownership to Optimacare. A new license (060910) was issued reflecting the new ownership with an effective date of July 26,2022. Element 4 - How the facility will monitor its	

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F 836	Continued From page 50 conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (2) All other changes in enrollment must be reported within 90 days." On 1/3/23 at 8:48 AM, upon arrival of the surveyors to the facility, the surveyor observed a facility entrance sign that had a name that did not correspond with the CMS licensed, approved name and provider registered name "Optima Care Castle Hill." As the surveyor approached the entrance door, an awning over the entrance door displayed the printed CMS licensed, approved and provider registered name, "Alaris Health at Castle Hill." Once the survey team entered the facility, there	F 836	corrective actions to ensure that the deficient practice is being corrected and will not recur. The Administrator will monitor daily that all facility operations; policy and procedures, letters and other communications reflect that Optimacare as the new owners and legally operating as such. Results of this observation and monitoring will be submitted to the QA committee monthly for the next 4 quarter for review, comments and recommendations.	

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was a displayed sign with the same name "Optima Care Castle Hill." The facility name displayed on the outside of the facility and in the lobby, "Optima Care Castle Hill" did not correspond with the CMS(Center for Medicaid and Medicare Services) licensed and approved name of "Alaris Health at Castle Hill."

On 1/3/23 at 9:50 AM, the State Surveyor along with the Federal Surveyor met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Assistant DON for Entrance Conference. During the discussion the facility management the facility was purchased by Optima in 2021 and changed the name of the facility some time after that.

On 1/3/22 at 11:16 AM, the surveyor reviewed various documents and facility policies that were provided by the LNHA that presented with "Optima Care Castle Hill" demonstrated on the title. The documents provided showed that the facility name that were being used were not according to the facility's licensed name and prior to CMS approved name/change of ownership approval.

On 1/4/23 at 10:53 AM, the state surveyor met with the LNHA to clarify the facility name. At this time, the surveyor discussed the facility's on line website which reflected that the CMS approved name of the facility, "Alaris Health at Castle Hill," was presented as "Permanently closed." The LNHA could not provide any information to explain this.

At this time, the LNHA reviewed the facility license with the State Surveyor and agreed that the "New Jersey Department of Health Division of

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Need and Licensing License" documented the name of the facility "Licensed to operate Alaris Health At Castle Hill" at the current address of the facility. The dates listed for operation under the license were 12/1/22 to 11/30/23 with an "Issued" date of 11/10/22.

During the meeting with the State Surveyor, the LNHA provided a letter that the facility received from the State of New Jersey Department of Health (NJDOH), dated 9/16/21. The letter references an application for transfer of ownership application received by the NJDOH on 7/19/21 that has been approved to proceed. The letter establishes, "approving your request to proceed with the transfer of ownership interests of Alaris Health at Castle Hill." The letter continues to present, "The referenced application submitted is for the transfer of ownership of Alaris Health at Castle Hill" from the previous owner to the current owner. In addition the letter establishes, "Simultaneously with the transfer of ownership, the Facility will be renamed Optima Care Castle Hill."

On page 2 of the NJDOH letter, "Although the new owner is authorized to operate the facility following the transaction, the Department will not issue the license under the new ownership until the items listed below are received and reviewed by staff from the Department." The letter continues to list a number of items that need to be submitted for the NJDOH to issue a new license for the new owners allowing them to change the name of the facility.

On 1/4/23 at 11:35 AM, the State Surveyor in the presence of the facility LNHA interviewed the facility Chief Operations Officer (COO) who

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F 836	Continued From page 53 explained that the facility is in the "transition process" of converting Alaris Health at Castle Hill to Optima Health at Castle Hill. On 1/4/23 at 12:43 PM, the State Surveyor in the presence of the facility LNHA met with the facility COO who presented the surveyor with the approval of application to proceed with transfer letter from the NJDOH, which was previously presented to the surveyor by the LNHA. In reviewing the letter, the COO agreed that the new ownership has not received authorization or approval to change the name of the building only authorization to proceed with the ownership change. On 1/5/23 at 2:00 PM, the State Surveyor met with the facility LNHA and DON to discuss the deficient practice of utilizing the facility name Optima Health at Castle Hill without NJDOH Licensure approval. No further information or documentation was provided to the survey team to refute these findings. NJAC 8:39-5.1 (a)	F 836		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		2/28/23

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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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F 880	Continued From page 55 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain proper infection control practices to mitigate the spread of infection for 4 of 25 Residents observed (Resident #34, #109, #107, #233), 2 of 3 floors of the facility observed (4th floor and 6th floor), during the facility COVID testing process and with the storage of clean linens. This deficient practice was evidenced by the following: 1. On 1/5/23 at 8:14 AM, the State Surveyor in the presence of a Federal Surveyor observed medication administration (med pass) on the 4th floor performed by a Licensed Practical Nurse #1 (LPN#1). LPN#1 completed administering medication to Resident #34 and proceeded to wash her hands. The State Surveyor along with the Federal Surveyor observed LPN#1 scrub her hands with soap for a total of 2 seconds before	F 880	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. >The residents noted in citation F880 1, 2, and 3 were identified as Residents #34, #107,and #109 as those affected by the facility staff (LPN 1 & LPN 2) not following the acceptable standard of practice for infection control and hand hygiene. There were no negative outcomes on the residents identified as a result of the deficient practice. >The residents occupying NJ Exec. Order 26:4.b.1 [redacted] were identified. There were no negative outcome noted as a result of the deficient practice. >The room where Resident #83 was residing was thoroughly cleaned and sanitized. There was no negative outcome noted as a result of the deficient practice.	

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F 880	Continued From page 56 placing her hands under water to rinse off the soap. 2. On 1/5/23 at 8:25 AM, the State Surveyor in the presence of a Federal Surveyor continued observation of medication administration on the 4th floor by LPN#1. LPN#1 prepared the medication and completed administering medication to Resident #109 without sanitizing or washing her hands that were not appropriately cleaned from med pass to Resident #34. LPN#1 only sanitized her hands at the end of the administration of medication to Resident #109 with an alcohol based hand sanitizer. 3. On 1/5/23 at 9:11 AM, the State Surveyor observed another med pass on the 4th floor by Licensed Practical Nurse #2 (LPN#2). LPN#2 completed administering medication to Resident #107 and proceeded to wash his hands. The State Surveyor observed LPN#2 scrub his hands with soap under water for 2 seconds while rinsing off the soap. On 1/5/23 at 9:27 AM, the State Surveyor interviewed LPN#2 who explained that he "sings happy birthday while his hands are under the water." On 1/5/23 at 9:32 AM, the State Surveyor interviewed LPN#1 who explained that she "scrubs her hands with soap away from the water for 60 seconds." LPN#1 further explained that she did not follow this process during the surveyor's observation, "because I didn't touch the patient. If you don't touch the patient, you don't have to wash your hands." The State Surveyor reminded LPN#1 that her hands were contaminated by the medication cup and water	F 880	>The resident identified in this citation, resident #83 is no longer at the facility. [redacted] was discharged to [redacted] on [redacted]. There was no negative outcome noted prior to [redacted] discharge as a result of this deficient practice. >There was no resident involved in this citation. However, there is a potential that other residents and staff who require to be tested on periodic basis can be affected by this deficient practice. > Linen storage in Room 1 and 2 on the first floor are now thoroughly cleaned. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. It was determined that there were no additional residents affected by the citations mentioned in F880 (1,2,3,4,4,5,6,7 and 8 sub-sections). However, all residents of this facility have the potential to be affected by all these deficient practices as cited. Element 3 - What measures will be put into place or systemeic changes made to ensure that the defcient practice would not recur. All staff was re-educated and continue to re-inforce by the DON and her designee about proper handwashing; the proper donning and doffing of PPE (Personal Protective Equipments); disinfecting and sanitizing contaminated equipments; door closures of rooms where Covid 19 residents are isolated. Return	

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F 880	Continued From page 57 cup that Resident #34 was holding during medication administration. LPN#1 responded, "I guess I should have washed my hands properly." Review of Hand Washing/Hand Hygiene Policy and Procedure revised on 3/9/21 opened with, "This facility considers handwashing /hand hygiene the primary means to prevent the spread of infections." Review of the "Procedure" portion of this policy under, "5. Rub all surfaces of hands, between fingers and wrist producing fiction for at least 15-20 seconds. 7. Rinse hands and wrist by holding them under running water with fingers downward the sink." The policy also adds, "The CMS SOM (Centers for Medicaid & Medicare Services State Operations Manual) indicates that hand hygiene should be performed as follows: Before and after performing any nursing procedure." Review of the facility Medication Administration Policy and Procedure indicated, "14. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves, isolation precautions etc.) when these apply to the administration of medications." On 1/5/22 at 2:00 PM, the surveyor met with the Director of Nursing (DON), Licensed Nursing Home Administrator and Assistant DON to discuss the breaches of infection control practices. No further information was provided during the survey to explain the deficient practice. 4. On 1/3/23 at 10:15 AM, prior to the initial tour of the COVID 19 positive residents' unit, the DON	F 880	demonstration and understanding of all these teaching were obtained. All licensed nurses were also re-educated by the DON about acceptable wound treatment process. A return demonstration was obtained from the licensed nurses. An in-service education was conducted by the Infection Preventionist (IP) about the proper Rapid testing technique as recommended by the manufacturer of Binax Now Covid Testing. A cleaning schedule of the linen storage rooms located on the first floor by the Housekeeping Director. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON and Administrator will perform a random check on 5-10 staff/week for the next 3 months about each citations (sub-sections 1,2,3,4 and 5). The DON or her designee will perform a random check during wound treament process 5xweek for the next 3 months. The Administrator will perform random check 5x/week for the next 3 months when Rapid Covid Testing is being performed. The Adminsitrator will check the cleanliness of the linen storage rooms (Room 1 & 2) 3x/week for the next 3 months. All the results of the audits and observations will be submitted to the QA	

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F 880	Continued From page 58 who was also the acting Infection Preventionist informed the surveyor that when touring the 6th floor, all staff and visitors must wear a face protection (face shield or goggles) and a N95 mask. On 1/3/23 at 10:34 AM, during the initial tour, the surveyor interviewed the 6th floor Licensed Practical Nurse/Unit Manager (LPN/UM). The LPN/UM stated to the surveyor that the unit had 2 residents who were placed on contact and droplet precautions due to being tested positive for COVID 19. The rooms were located at the end of the hallway, NJ Exec. Order 26:4.b.1. The two rooms were across from one another. On 1/3/23 at 10:43 AM, while the surveyor was standing in the hallway between the rooms 601 and 602, the resident's doors were observed to be open. The surveyor further observed a housekeeper sweeping the hallway floor who was not wearing eye protection or face shield and the N95 mask was not properly worn (only top elastic part of the mask was around the housekeeper's head). The surveyor interviewed the housekeeper who stated that the bottom elastic of her N95 mask was broken and acknowledged that she had no eye/face protection while at the COVID 19 side of the unit. 5. On 1/3/23 at 10:57 AM, the surveyor observed that the room where Resident #83 resided had a Personal Protective Equipment (PPE) cart at the entrance to the resident's room. The surveyor interviewed the Registered Nurse (RN) who was assigned to the resident who stated that Resident #83 was placed on NJ Exec. Order 26:4.b.1 [redacted]. The	F 880	committee for review, comments and recommendations.	

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F 880	Continued From page 59	F 880		

RN further stated that Resident #83 will be under observation for the next 10 days.

The surveyor wearing full PPE, went inside Resident #83's room and observed the resident's call bell was touching the floor. The surveyor showed the call bell to the RN who then picked it up and placed it on top of the resident's bedside table next to the resident's personal items. The surveyor observed the RN disinfecting the call bell and the wire connected to it then handed the call bell to the resident. The RN did not disinfect the contaminated bedside table where she initially placed the call bell (that was previously on the floor) next to the resident's personal items. The RN acknowledged that she did not disinfect the bedside table and agreed that she should have.

6. On 1/11/23 at 9:23 AM, the surveyor in the presence of a Federal Surveyor observed a NJ Exec. Order 26:4.b.1 performed by a 6th floor Licensed Practical Nurse (LPN) assigned to Resident #233, who had a NJ Exec. Order 26:4.b.1 [redacted]

The surveyor observed the LPN NJ Exec. Order 26 4.b.1 [redacted] from Resident #233, that covered the EX Order 26 § 4b1 . The LPN then proceeded to remove her disposable gloves and perform handwashing. After putting on a clean pair of disposable gloves, the surveyor observed that the LPN cleansed the EX Order 26 § 4b1 [redacted] EX Order 26 § 4b1 [redacted] The LPN was observed to be cleaning the EX Order 26 § 4b1 [redacted].

After the NJ Exec. Order 26:4.b.1 observation, the

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	315344	A. BUILDING _____ B. WING _____	C 01/13/2023

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 60	F 880		

surveyor interviewed the LPN who stated that when she cleansed a EX Order 26 § 4b1, she would utilize the top to bottom stroke.

A review of the facility's policy titled; "EX Order 26 § 4 " did not indicate specifically on how to EX Order 26 § 4b1.

According to the National Pressure Ulcer Advisory, "When cleansing a wound ... ... The wound should be cleaned from the inner to the outer portions of the wound. This keeps the wound from being contaminated with bacteria from outside the wound. The wound should be cleansed at least 1 inch (2.5 cm) beyond the end of the new dressing. Also, the wound should be cleansed in full or half circles beginning in the center and working toward the outside."

On 1/12/23 at 2:00 PM, the above concern was discussed with the LNHA, DON and MDS Coordinator who all agreed that the pressure ulcer should have been cleaned in an inner to outer stroke. No further information was provided.

7. On 1/10/23 at 1:24 PM, the surveyor in the presence of the Federal surveyor observed the facility's COVID 19 testing that was performed by the DON.

The surveyor observed the DON open a BinaxNOW COVID 19 Ag testing card from the package then proceed to obtain the bottle of the Extraction Reagent. The surveyor then observed that the DON added 7 drops of the Extraction Reagent to the BinaxNOW COVID 19 Ag testing card.

On 1/10/23 at 1:29 PM, the surveyor observed

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	315344	A. BUILDING _____ B. WING _____	C 01/13/2023

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

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F 880	Continued From page 61	F 880		

the DON swabbed the nostril of the facility's dietary staff. The surveyor noted that the DON did not swab the staff member's nostril in a circular motion or for at least 15 seconds.

The DON then proceeded to insert the control swab inside the BinaxNOW COVID 19 Ag testing card. The DON informed the surveyor, "after a few minutes, it will show one red line in the card if the staff is tested negative and two red lines if the staff will test positive". The surveyor asked the DON if she had documented the time when she swabbed the staff and the time when she inserted the swab in the card. The DON responded that she does not have the exact time.

The DON explained that the timer that was on top of the table was broken. The DON identified that there was no other clock located around the testing area for her to monitor the testing time.

On 1/10/23 at 1:31 PM, when the DON checked on the BinaxNOW COVID 19 Ag testing card, there were no lines noted and the strip of the card was observed to be soaked from the solution that appeared to be all white in color. The DON discarded the BinaxNOW COVID 19 Ag testing card.

On 1/10/23 at 1:38 PM, the DON retested the same facility's dietary staff's nostril following the BinaxNOW COVID 19 Ag directions and adding 6 drops of liquid to the card receptacle area. The surveyor continued the observation and noted that the DON did not swab the staff member's nostril in a circular motion or for at least 15 seconds.

On 1/10/23 at 1:45 PM, the DON showed the

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F 880	Continued From page 62	F 880		

surveyor the BinaxNOW COVID 19 Ag testing card which revealed one red line on the top of the strip. This was less than 15 minutes. The DON stated to the surveyor that the staff was negative for COVID 19 since it only showed one red line then proceeded to discard the BinaxNOW card.

The DON informed the surveyor that the wait time after the swab was inserted inside the BinaxNOW COVID 19 Ag testing card was 10 minutes.

On 1/10/23 at 1:51 PM, another dietary staff was swabbed by the DON using the same technique as described above. The surveyor noted that the DON did not swab the staff member's nostril in a circular motion or for at least 15 seconds. The surveyor did observe the DON put 6 drops into the liquid receptacle area of the test card.

The surveyor observed the DON insert the control swab sample inside the BinaxNOW COVID 19 Ag testing card at 1:52 PM. The DON informed the surveyor that the result would be due to be read by 2:07 PM (15 minutes).

On 1/10/23 at 2:01 PM, the DON presented the BinaxNOW COVID 19 Ag testing card result, which revealed one red line on the top of the strip indicating that the staff tested negative for COVID 19. The DON did not wait the recommended time and read the result after 15 minutes.

Review of the BinaxNOW COVID 19 Ag testing instruction packet demonstrates:
"Prepare for the test: Timing Device (not included)
1. Wash or sanitize your hands. Make sure they are dry before starting.
3. Put 6 drops into top hole. Do not touch card

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F 880	Continued From page 63	F 880		

with tip.
5. Make at least 5 big circles. Do Not just spin the swab. Each nostril must be swabbed for about 15 seconds.
7. Turn swab to right 3 times to mix the swab with the drops
9. Wait 15 minutes. Read the result at 15 minutes. Do not read the result before 15 minutes or after 30 minutes."

On 1/11/23 at 11:00 AM, the surveyor discussed the above concerns with the facility's LNHA and DON who could not explain why the BinaxNOW COVID 19 Ag instructions were not accurately followed during staff testing. No further information was provided.

8. On 1/10/23 at 10:41 AM, the surveyor in the presence of the Federal surveyor, Housekeeping Director (HD) and the Housekeeping Supervisor (HS) observed the two rooms where the clean linens were stored. The HD and HS informed the surveyors that clean linens were delivered from an outside laundry company to the facility and stored in room #1. Upon entering room #1, where the clean linens were stored, the surveyors observed that there was a large black bin that contained garbage materials, once inspected. The surveyor also observed on the side of the wall right next to the door, that there were several items including 2 unused N95 masks on the floor, a fork, a broom, and a magazine.

The HD and HS showed the surveyor another room, room #2 where the clean linens from room #1 were transferred, separated, and placed onto transport shelved bins that can be brought to the facility units for use. The surveyor observed the floor of room #2 to be dirty with several dried

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	315344	A. BUILDING _____ B. WING _____	C 01/13/2023

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F 880	Continued From page 64 leaves and some disposable utensils on the floor. Further observation also revealed that there were cobwebs on the far corner of the room opposite to where the clean linens were stored on the shelved bins. The HD and HS stated to the surveyors that the items (2 unused N95 masks on the floor, a fork, a broom, and a magazine) found in linen room #1 should not be there, since clean linens were stored in the room. The HS and HD acknowledged that since clean linens are stored in room #2 as well, the room should be clean without evidence of cobwebs and a dirty floor. NJAC 8:39 - 19.4(a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060910	A. BUILDING: _____ B. WING _____	C 01/13/2023

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 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 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.	S 560	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no reported negative outcome as a result of this citation. 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	2/28/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060910	A. BUILDING: _____ B. WING _____	C 01/13/2023

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S 560	Continued From page 1 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 staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of	S 560	into place or systemic changes made to ensure that the deficient practice would not recur. This facility recognizes the shortage of CNA during the dates mentioned (12/18; 12/24 and 12/25/2022). This facility has obtained additional contracts with 2 staffing agencies to satisfy the staffing needs. The facility will continue to offer incentives (Overtime, Bonus etc.) to current working staff. Element 4 -How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or her designee will check staffing daily including the weekend and holidays for adequacy and compliance. The results of this review will be submitted to the QA committe quarterly for comments and recommendations.	

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S 560	Continued From page 2	S 560		

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 weeks of 12/18/22 and 12/24/22 revealed the following:

The facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:

-12/18/22 had 13 CNAs for 131 residents on the day shift, required 16 CNAs.
-12/24/22 had 15 CNAs for 137 residents on the day shift, required 17 CNAs.
-12/25/22 had 12 CNAs for 137 residents on the day shift, required 17 CNAs

On 1/9/23 at 12:45 PM., the surveyor informed the Director of Nursing, Licensed Nursing Home Administrator (LNHA) of the staffing ratio concerns. No further information was provided.

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	3/13/2023 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 F0582	Correction	ID Prefix F0655	Correction	ID Prefix F0656	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
ID Prefix F0657	Correction	ID Prefix F0658	Correction	ID Prefix F0661	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
ID Prefix F0676	Correction	ID Prefix F0695	Correction	ID Prefix F0757	Correction
Reg. # 483.24(a)(1)(b)(1)-(5)(i)-(iii)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(d)(1)-(6)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
ID Prefix F0759	Correction	ID Prefix F0801	Correction	ID Prefix F0836	Correction
Reg. # 483.45(f)(1)	Completed	Reg. # 483.60(a)(1)(2)	Completed	Reg. # 483.70(a)-(c)	Completed
LSC	02/28/2023	LSC	02/28/2023	LSC	02/28/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/28/2023	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?
1/13/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060910 Y1	A. Building B. Wing Y2	3/13/2023 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/28/2023	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	
1/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING **01** B. WING _____	C **01/13/2023**

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 000	INITIAL COMMENTS 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 (Gillette 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 that was last inspected: 05/26/2022. The facility has 215 certified beds. At the time of the survey the census was 129. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 281 SS=E	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 observation and interview, in the presence of facility Maintenance Director (MD), it was determined that the facility failed to provide	K 281	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the	2/28/23

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

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K 281	Continued From page 1 emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 1 of 6 exit access areas observed. This deficient practice evidenced by the following: On 1/4/23 at 1:03 PM, the surveyor in the presence of the MD, observed in the floor-2 occupied "New Horizon Day Room" that 1-wall light switch would shut-off all the 13 light fixtures. Once the light switch was turned off, the means of egress had no form of lighting. The MD, confirmed the finding at the time of observation. No further information was supplied. The MD was informed of these findings at the Life Safety Code survey exit conference on 1/5/23. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	deficient practice. All the residents were assessed, there were no negative outcome from any residents as a result of this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any Life Safety citations. Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. An outside contractor (Star Low Electrical) was hired and transferred 4 light fixtures from Normal Power to the emergency circuit. These 4 light fixtures no longer turn off when light switch is turned-off. This light fixture will serve as a lighting for the New Horizon Day Room. This job was completed on 02/21/2023. The MD or his designee will inspect monthly the New Horizon lighting and other common areas and hallways in the facility that require egress lighting to check for functionality. This task will be done for the monthly for the next 3 months then annually thereafter. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and	

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K 281	Continued From page 2	K 281	will not recur. The results of the monthly inspection completed by the MD or his designee will be submitted to the Administrator monthly for compliance then subsequently be submitted to QA committee quarterly for the next 4 quarter for comment, review and recommendations.	
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide a battery back-up emergency light above the fire pump transfer switches independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was identified for 2 of 2 separate transfer switches observed. The deficient practice was evidenced by the following: On 1/4/23 at 10:32 AM, the surveyor in the presence of the MD, observed in the fire pump room, that the fire pump electrical panel transfer switches 2 of 2, did not have any emergency lighting. The MD confirmed the finding at the time of the	K 291	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no negative outcome from any residents as a result of this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any Life Safety citation. Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.	2/10/23

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K 291	Continued From page 3 observations. No further information was provided. The MD was informed of the finding at the Life Safety Code exit on 1/5/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	A battery back-up emergency light has been installed above the fire pump transfer switches in the fire pump room. Element 4 - How the facility will monitor monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Maintenance Director (MD) or his designee will check the fire pump room 3x/week for the next 3 months for emergency lighting. This will remain to be a routine task of MD or his designee monthly after 3 months. The results of these observation will be submitted quarterly to the QA committee for comment and recommendations.	
K 311 SS=E	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 review of facility documentation on 1/4/2023 in the presence of facility Management it was determined that the	K 311	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the	2/10/23

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K 311	Continued From page 4 facility failed to ensure that 6 of 18 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This is evidenced by the following: On 1/4/2023 during the survey entrance at 9:20 AM, a request was made to the Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are six floors with 3 exit stairwells in the facility. Starting at 9:40 AM, in the presence of the facility's DOM a tour of the building was performed. During the tour the surveyor performed closure tests of the eighteen (18) 1-1/2 hour fire rated corridor doors leading into stairwells with the following results, 1. On 1/4/23 at approximately 10:50 AM, on the 5th. floor during a closure test of the exit access door leading into the stairwell #2 (west side) when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. 2. On 1/4/23 at approximately 11:00 AM, on the 5th. floor during a closure test of the exit access door leading into the stairwell #1 (east side) when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results.	K 311	deficient practice. There were no negative outcome from any residents as a result of this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any Life Safety citation Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The Maintenance Director (MD) with the assistance of his staff identified all the 6 doors that were found not to positively latch into its frame. All of the doors mentioned in the this citation were immediately adjusted by the MD and are now positively latching 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 MD or his designee will conduct random checks on at least 5 exit doors/week for the next 3 months for proper positive latching into its frames. After 3 months, this will remain to be a routine of MD checklist monthly. Results of the random checks of the doors will be	

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K 311	Continued From page 5 3. On 1/4/23 at approximately 11:18 AM, on the 4th. floor during a closure test of the exit access door leading into the stairwell #2 (west side) when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. 4. On 1/4/23 at approximately 11:27 AM, on the 4th. floor during a closure test of the exit access door leading into the stairwell #1 (east side) when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. 5. On 1/4/23 at approximately 11:40 AM, on the 3rd. floor during a closure test of the exit access door leading into the stairwell #2 (west side) when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. 6. On 1/4/23 at approximately 11:46 AM, on the 3rd. floor during a closure test of the exit access door leading into the stairwell #1 (east side) when tested and allowed to self-close into its frame, the door did not positive latch into its frame. This test was repeated two additional times with the same results. The stairwell doors would need to positive latch into its frame to maintain the fire rated	K 311	submitted to the QA committee quarterly for review, comments and recommendations.	

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K 311	Continued From page 6 construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The DOM confirmed the findings at the time of observations. No further information was provided. The DOM was notified of the deficiency at the Life Safety Code exit conference on 1/04/2023 at approximately 1:45 PM.. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 311		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/5/23, in the presence of the Maintenance Director (MD), it	K 341	Element 1 -How the corrective action will be accomplished for those residents	2/28/23

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K 341	Continued From page 7 was determined that the facility failed to install supervised smoke/heat detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. This deficient practice was observed in 1 of 1 kitchen areas and was evidenced by the following: On 1/5/23 at 10:29 AM, the surveyor and MD, observed that the facility failed to provide supervised smoke/heat detection in the kitchen. The surveyor observed no evidence of a smoke/heat detector within 20 feet of the cooking system as required by code. The MD confirmed the finding during the kitchen observation. No further information was provided. The Maintenance Director was notified of the finding at the Life Safety Code exit conference on 1/5/23. NJAC 8:39 -31.2 (a).	K 341	found to have been affected by the deficient practice. All residents were assessed, there were no negative outcome from any residents as a result of this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any 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 recur. Van Well Electric Company has installed a supervised smoke/heat detector unit in the kitchen by the cooking area on 2/21/2023 as per compliance with NFPA 101, 2012 Edition. The MD or his designee will monitor monthly the functionality of the supervised smoke/heat detector in the kitchen. This task will remain on-going as part of the monthly preventative maintenance program done by the MD or his designee. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The MD will report to the Administrator	

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K 341	Continued From page 8	K 341	the results of his monthly inspections of the smoke/heat detector and subsequently submit the report to the QA committee quarterly for review, comments and recommendaions.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/4/2023, it was determined that the Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey	K 351	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents were assessed and there were no negative outcome from any residents as a result of this citation.	3/10/23

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K 351	Continued From page 9 Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice is evidenced by the following, On 1/4/2023 during the survey entrance at 9:20 AM, a request was made to the Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are six floors in the facility. Starting at 9:40 AM, in the presence of the facility's DOM a tour of the building was performed. Along the tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: 1. On 1/4/23 at approximately 11:09 AM, the surveyor observed inside the 5th. floor Men's shower room one 46 inch wide by 6 feet 9 inch deep shower stall had no evidence of fire sprinkler coverage. The surveyor observed one fire sprinkler in the shower area for the 2nd. shower stall. This fire sprinkler would not reach around the divider wall between the two shower stalls in the area. At this time the surveyor asked the DOM if the sprinkler in the area would reach into the other 1st. shower stall. The DOM said, no. 2. On 1/4/23 at approximately 11:11 AM, the surveyor observed inside the 5th. floor Ladies shower room one 46 inch wide by 6 feet 9 inch deep shower stall had no evidence of fire sprinkler coverage. The surveyor observed one fire sprinkler in the shower area for the 2nd.	K 351	Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any 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 recur. All the shower rooms found to require additional shower heads to comply with the code on the 5th floor men and ladies shower rooms; 4th floor men and ladies shower rooms; 3rd men and ladies shower rooms; the center corridor on the 2nd floor storage area will have additional sprinkler heads installed by the Fire Fighter Sprinkler Company with an estimated job completion date by 3/10/23. The plywood wood attached to the chicken wire netting along the hallway on the 2nd floor storage room has at least 2' opening to the ceiling. Upon consultation with the local fire officials on 2/15/23, the plywood cannot be closed in all the way to the top ceiling because it will block the existing sprinkler heads already mounted inside each cages and plus the ones that will be installed along the hallways. The plywood in the storage areas that divide the cages are currently being treated by the maintenance staff with flame resistant paint coating to reduce the	

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K 351	Continued From page 10 shower stall. This fire sprinkler would not reach around the divider wall between the two shower stalls in the area. At this time the surveyor asked the DOM if the sprinkler in the area would reach into the other 1st. shower stall. The DOM said, no. 3. On 1/4/23 at approximately 11:29 AM, the surveyor observed inside the 4th. floor Men's shower room one 47 inch wide by 6 feet 8 inch deep shower stall had no evidence of fire sprinkler coverage. The surveyor observed one fire sprinkler in the shower area for the 2nd. shower stall. This fire sprinkler would not reach around the divider wall between the two shower stalls in the area. 4. On 1/4/23 at approximately 11:33 AM, the surveyor observed inside the 4th. floor Ladies shower room one 46 inch wide by 6 feet 9 inch deep shower stall had no evidence of fire sprinkler coverage. The surveyor observed one fire sprinkler in the shower area for the 2nd. shower stall. This fire sprinkler would not reach around the divider wall between the two shower stalls in the area. 5. At approximately 11:45 AM, the surveyor observed inside the 3rd. floor Men's shower room one 46 inch wide by 6 feet 9 inch deep shower stall had no evidence of fire sprinkler coverage. The surveyor observed one fire sprinkler in the shower area for the 2nd. shower stall. This fire sprinkler would not reach around the divider wall between the two shower stalls in the area. 6. At approximately 11:48 AM, the surveyor observed inside the 3rd. floor Ladies shower room one 46 inch wide by 6 feet 9 inch deep	K 351	risk of ignition. This task will be completed on 2/28/23. In an effort to ensure that residents are protected as cited on this tag until all the job order are completed, the MD and/or his designee and housekeeping staff will inspect the shower rooms 2x daily until 03/30/23. The inspection by the MD and housekeeping staff will ensure that no flammable materials are left behind after each use by the resident and or staff. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The MD will inspect that the recent job order was thoroughly complete with no gaps or any penetrations monthly. The contracted vendor performs their quarterly inspections yearly of all the sprinkler heads which will include the recent installation. The results will be submitted to the Administrator monthly then subsequently to the QA committee quarterly for review, comments and recommendations.	

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K 351	Continued From page 11 shower stall had no evidence of fire sprinkler coverage. The surveyor observed one fire sprinkler in the shower area for the 2nd. shower stall. This fire sprinkler would not reach around the divider wall between the two shower stalls in the area. The DOM confirmed the findings at the time of observations. No further information was provided. The DOM was notified of the deficiency at the Life Safety Code exit conference on 1/04/2023 at approximately 1:45 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13. Based on observation, interview and record review on 1/4/22, in the presence of the Director of Maintenance (DOM), it was determined that the facility failed to a.) provide complete sprinkler coverage as required by Centers for Medicare/Medicaid Services regulation § 483.90(a) physical environment and b.) to install the sprinkler system in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5, 4.6.12 and 9.7, NFPA 13, 2012 Edition, Section 6.2.7.1, 8.1, 8.1.1, 8.5.2.1, 8.5.5, 8.5.5.2 8.15.7, 8.15.7.1 and 8.15.7.5. The lack of sprinkler coverage could delay or prevent the extinguishment of a fire in these areas. This deficient practice was identified for 1 of 1 storage room's on floor-2 of the facility and was evidenced by the following: On 1/4/23 at 12:50 PM, the surveyor and DOM observed in the floor-2 storage room approximately 25' x 50', that the center corridor of the room was separated left and right by metal	K 351		

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K 351	Continued From page 12 studs. The center corridor was approximately 5' x 50'. The metal studs were observed to have chicken wire netting and 3/4" plywood attached. The untreated plywood was installed approximately 7' up from the floor leaving approximately 2' opening to the ceiling. The unprotected center corridor of the storage room did not have any fire sprinkler protection. The DOM was asked to provide any documentation on the flammability rating of the plywood and he stated that it has been there for many years and he could not produce any further documentation. The facility fire sprinkler vendor inspection reports indicated on 11/29/22, 8/15/22, 5/26/22 and 2/21/22 that the "2nd floor storage corridor may need additional sprinkler coverage" The DOM confirmed the observations during the floor-2 storage room tour and record review. No further information was provided. The DOM was informed of the findings at the Life Safety Code exit conference on 1/5/23.	K 351		
K 353 SS=E	NJAC 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.	K 353		3/10/23

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K 353	Continued From page 13 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 surveyor observation on 1/4/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to: A) maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. B) ensure the electric fire pump was operating in optimal condition. This deficient practice was evidenced in 4 of 4 facility fire sprinkler quarterly reports and 1 of 1 fire pump annual test reports and evidenced by the following: A. On 1/4/23 at 10:25 AM, the Maintenance Director provided the required fire sprinkler system inspection reports dated: 11/29/22, 08/05/22, 05/26/22 and 02/21/22. All the report's "Recommend replacing the OS&Y valve at the base of the sprinkler riser that is very difficult to operate". The MD confirmed the finding's during document review and confirmed the recommendations on the reports. B. On 1/4/23 at 10:45 AM, the surveyor observed the annual electric fire pump performance test	K 353	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents were assessed and found no negative outcome from any residents as a result of this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any 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 recur. The Fire Fighter Sprinkler Company is contracted to replace the existing OS&Y valve at the base of the sprinkler riser and complete all the work order (install Fire Pump Casing relief valve and install an Air	

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K 353	Continued From page 14 dated: 05/26/22. The report indicated: 1. The pump casing relief valve doesn't operate and should be replaced. 2. Recommend installing an "Air Vent" on top of the pump casing. The MD confirmed the findings on the fire pump performance test report dated: 5/26/22. No further information was provided. The MD was informed of the findings at the life safety code exit conference on 1/5/23. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	Vent)by 3/10/2023. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. All the repairs and installation of new parts and units will be inspected by the MD or his designee for its functionality upon completion of the work order monthly. The MD will inspect the repaired and replaced units monthly for the next 3 months. The results of his inspection will be submitted to the Administrator monthly and subsequently be submitted to the QA committee quarterly for review, comments and recommendations.	
K 355 SS=E	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 observation and interview on 1/4/23 in the presence of the Maintenance Director (MD), it was determined that the facility failed to A) ensure that fire extinguishers were not blocked or obstructed in any way that would delay staff from accessing the fire extinguisher in the event of an emergency for 1 of 25 extinguishers observed and B) perform and document on the tag	K 355	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no negative outcome from any residents as a result of this citation.	2/10/23

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K 355	Continued From page 15 attached to the fire extinguisher a monthly visual examination for 2 of 2 ansul fire suppression system tags in the facility kitchen. This deficient practice was evidenced by the following: A. On 1/4/23 at 12:56 PM, the surveyor observed in the floor-2 exit/egress corridor that a plastic beige trash can was stored in front of a wall mounted fire extinguisher enclosed cabinet. The MD confirmed the finding during the observation. B. On 1/4/23 at 2:10 PM, the surveyor observed that the main kitchen ansul system activation device and extinguisher wall mounted cabinet were both provided with monthly inspection tags. The ansul tags 2 of 2 were marked: 7/13/22 and 11/14/22 only. The MD confirmed the findings, during the observations. The MD was informed of the findings at the Life Safety Code exit conference on 01/05/23. No further information was provided. NJAC 8:39-31.2(e) NFPA 10, Standard for Portable Fire Extinguishers.19.3.5.12, NFPA 10 NFPA 96 UL 300 standard for fire testing of fire extinguishing systems for protection of commercial cooking equipment	K 355	Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any Life Safety Code citations. Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The plastic beige trash can that was stored in front of a wall-mounted fire extinguisher on the 2nd floor exit/egress corridor has been removed. All fire extinguisher locations in the building were inspected; no blockages or obstruction were noted. The Ansul Fire supression system in the main kitchen were re-inspected and are now marked accordingly. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The MD or his designee will randomly check all the locations of the fire extinguishers in the building weekly to ensure that no obstructions or blockages exist. The Ansul System will be checked monthly by the MD or his designee. This will be a routine checklist by the MD or his designee to accomplish monthly. The	

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K 355	Continued From page 16	K 355	results of this random checks will be reported to the QA committee quarterly for the next 3 months.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 1/4/23, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 6 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4	K 374	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents were assessed and found no negative outcome from any residents as a result of this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any Life Safety	2/28/23

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K 374	Continued From page 17 of an inch. On 1/4/2023 during the survey entrance at 9:20 AM, a request was made to the Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are six floors in the facility. On 1/4/23 starting at 9:40 AM, in the presence of the facility's DOM a tour of the building was performed. The surveyor performed closure tests of the six (6) sets of smoke barrier doors in the corridors with the following results, On 1/4/2023 at approximately 10:52 AM, during a closure test of one set of double smoke doors on the sixth floor, when both doors were release from their magnetic hold open devices and allowed to self close into their frame, the surveyor observed and measure a 1-1/8 of an inch gap along the bottom edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The DOM confirmed the findings at the time of observations. No further information was provided. The DOM was notified of the deficiency at the Life Safety Code exit conference on 1/04/2023 at approximately 1:45 PM. N.B. 8:39-31.1(c), 31.2(e)	K 374	Code citation Element 3 - What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The smoke barrier doors on the 6th floor that was found to exceed the acceptable clearance at the bottom edge of the door is now fixed to close the gaps on 02/21/2023. New door sweeps were purchase and replaced the existing ones on 02/21/2023. All other smoke barrier doors were checked to ensure that all doors are in compliance with the code on 02/21/2023. All smoke barrier doors and door sweeps in the entire building were inspected on 2/21/2023, all were found in compliance. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The MD or his designee will inspect all smoke door barriers of the building monthly for the next 3 months to comply with the code. Results of these inpections will be submitted to the Administrator monthly and subsequently to the QA committee quarterly for review, comments and recommendations.	

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K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 1/4/23, in the presence of the Surveyor and Maintenance Director (MD), the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. The practice of dumping cigarette butts and ash into trash cans with other combustibles, increases the risk of fire to facility occupants. This	K 741	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents were assesssed and found no negative outcome from any residents as a result of this citation.	2/28/23

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K 741	Continued From page 19 deficient practice was evidenced for 1 of 1 smoking areas observed and was evidenced by the following: On 1/4/23 at 1:14 PM, the surveyor and MD observed in the occupied floor #2 smoking deck approximately 19' x 50' that a combustible off white flip top plastic garbage container was located against the building. The container was observed to have cigarette butts and ash along with other combustible items: Plastic cups, cardboard and paper mixed together. The container was not an approved astray for disposal of cigarette butts. There were no approved self-closing covered metal container's for the disposal of cigarette butts and ashes in the area. The finding was verified by the MD at the time of the observation. No further information was provided. The MD was informed of the finding at the Life Safety Code exit conference on 1/5/23. NJAC 8:39-31.2(e)	K 741	Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any 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 recur. The trash can found in the smoking area on the second floor was immediately removed from the smoking area on 1/04/23 to ensure that cigarette butts and other combustibles are not thrown into a trash can, thus increases risk of fire at the facility. 4 self-closing cover metal containers to be used as ashtrays were purchased and delivered. 3 were placed by the smoking area on the 2nd floor on 02/22/2023. 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 and/or MD will inspect the smoking area 3x weekly during building rounds. This will be an on-going task as part of QAPI program. The results of these observations will be submitted to the QA committee quarterly for comments, and recommendations.	

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K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 1/4/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 12 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 1/4/2023 during the survey entrance at 9:20 AM, a request was made to the Director of Maintenance (DOM), to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are six floors in the facility. On 1/4/23 starting at 9:40 AM, in the presence of the facility's DOM a tour of the building was performed. During the tour of the facility, the surveyor observed and tested twelve (12) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following,	K 911	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no negative outcome from any residents as a result of this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any 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 recur. The GFCI outlet by sink in room 448 was replaced with a new unit. Element 4 - How the facility will monitor its corrective actions to ensure that the	2/10/23

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K 911	Continued From page 21 On 1/4/23 at approximately 11:21 AM, inside Resident room # 448 when the surveyor tested a the GFCI electrical outlet located 8 inches to the left of the sink with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. The DOM confirmed the findings at the time of observations. No further information was provided. The DOM was notified of the deficiency at the Life Safety Code exit conference on 1/04/2023 at approximately 1:45 PM.. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	deficient practice is being corrected and will not recur. The MD or his designee will randomly test 5 GFCI outlets monthly. Results of of the tests will be reported to the Administrator during QA quarterly meeting.	
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	K 914		2/28/23

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K 914	Continued From page 22 repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 1/4/23, in the presence of the facility's Maintenance Director (MD), it was determined that the facility failed to functionally test electrical receptacles in resident rooms annually for grounding, polarity, and blade tension in accordance with NFPA 99. Maintenance and testing 6.3.3.2 Receptacle Testing in Patient Care Rooms. This deficient practice was evidenced by documentation review and interview with the MD, for all resident rooms by the following: Record Review of the facility's annual electric inspection report from the facility vendor dated : 12/28/22 indicated a visual re-inspection electrical survey only. The MD indicated resident rooms were provided with electrical receptacles that were less than hospital grade except on floor#6 (hospital grade) and required an annual electrical inspection. The MD could not provide an inventory list of hospital grade and non hospital grade outlets. The last annual electrical inspection by the facility vendor dated 12/28/22, indicated that there was no documentation for the annual inspection and itemized list of receptacle testing in patient care rooms. An interview was conducted with the MD, during document review. The MD stated that he was unsure if the facility electrical vendor was doing this inspection and currently could not provide	K 914	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents in the facility were assessed and no negative outcome was observed as a result of the citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents in the facility have the potential to be affected by any 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 recur. Testing of residents room requiring functional testing has already started by the MD and his designee with a target completion date of 2/28/2023. MD and/or his designee will use the Annual Electrical Inspection checklist to ensure that all resident's room with non-hospital grade electrical receptacles will be inspected at lease annually. Element 4 - How the facility will monitor its	

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K 914	Continued From page 23 any documentation this inspection was being performed. No further information was provided. The Maintenance Director was informed of the finding's at the Life Safety Code exit conference on 1/5/23. NJAC 8:39-31.2(e) 6.3.4 (NFPA 99)	K 914	corrective actions to ensure that the deficient practice is being corrected and will not recur. The MD or his designee will audit at least 10 affected rooms monthly to ensure compliance with the annual electrical inspection codes. Results of the audit will be submitted to the Administrator monthly then subsequently submit to QA committee quarterly for review, comment and recommendations	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918		2/10/23

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING **01** B. WING _____	C **01/13/2023**

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 24 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review on 1/4/23 in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that the 125 KW Gillette generator was in optimal condition, This deficient practice was evidenced for 1 of 1 facility generator's by the following: On 1/4/23 at 11:48 AM, the surveyor reviewed all documentation for the facility generator dated: 11/30/22. The facility generator vendor indicated that the "radiator fins were clogged with oily/dusty gunk" and indicated that the radiator needs to be removed and power washed and coolant flush. The Maintenance Director confirmed the finding reported by the generator vendor inspection report dated 11/30/22. No further information was provided. The Maintenance Director was informed of the finding at the Life Safety Code exit conference on 1/5/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	Element 1 -How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents in the facility were assessed and there were no negative outcome as a result of this citation. Element 2 - How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents at the facility have the potential to be affected by any 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 recur. A facility generator vendor report dated 12/27/2022 was obtained and filed in the Maintenance Binder on 1/30/2023. The 12/27/2022 report indicated that the	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING **01** B. WING _____	C **01/13/2023**

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 918	Continued From page 25	K 918	11/30/2022 findings of the "radiator fins being clogged with oily/dusty gunk" was corrected to ensure that the generator was in optimal condition. Element 4 - How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The MD will review and follow-up on all outstanding and completed work orders weekly . Documentation for completed work orders will be filed in the Maintenance Binder by the MD. The MD will audit completed and outstanding work orders weekly x4weeks then monthly x 6 moths. All audit reports will be submitted to the Administrator monthly then subsequently submitted to the QA committee quarterly for review, comments 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 01 - MAIN BUILDING 01 B. Wing Y2	3/13/2023 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 K0281	02/28/2023	LSC K0291	02/10/2023	LSC K0311	02/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0341	02/28/2023	LSC K0351	03/10/2023	LSC K0353	03/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	02/10/2023	LSC K0374	02/28/2023	LSC K0741	02/28/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0911	02/10/2023	LSC K0914	02/28/2023	LSC K0918	02/10/2023
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	
1/13/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO