STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING _____ B. WING _____	C 08/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00176536 , NJ00176590 Census: 134 Sample Size:4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of documentation, the facility failed to consistently maintain a functional Heating, Ventilation and Air Condition Unit (HVAC) in good repair on 1 of 3 nursing units (3rd floor) in order to maintain a comfortable environment for its residents, staff, and visitors . This deficient practice was evident by the following: On 08/29/24, at 10:30 am., the surveyor conducted a tour of an empty 3rd floor unit with the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) [redacted]. According to the [redacted] a decision was made to utilize the 3rd floor unit to accommodate [redacted] for NJ Ex Order 26.4(b)(1) [redacted] residents and 9 residents NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b)(1)	F 921	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents that were temporarily moved to the 3rd floor on [redacted] and [redacted] to accommodate NJ Ex Order 26.4(b)(1) [redacted] plus [redacted])residents NJ Ex Order 26.4(b)(1) that require [redacted] were altogether moved out of the 3rd floor on 8/28/24 at approximately 8:00 PM to a different unit with more acceptable room temperature. While on the 3rd floor unit, Resident # 2 and Resident #3 were provided with an electric fan AND a portable air	8/30/24

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

Electronically Signed | 10/01/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING _____ B. WING _____	C 08/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 1 residents and 9[NJ Ex Order 26.4(b)(1)] were housed on this unit from [NJ Ex Order 26.4(b)(1)] to [NJ Ex Order 26.4(b)(1)]. During the tour, the [U.S. FOIA] stated that 3rd floor unit had been closed for over one year and the air conditioning units were not working. The decision was made to transfer the [NJ Ex Order 26.4(b)(1)] residents to this floor on [NJ Ex Order 26.4(b)(1)]. The [U.S. FO] stated that the 3rd floor was not on his daily maintenance rounds inspections. The surveyor observed there were no residents on the floor during the tour. The thermostat on the wall indicated 74 degrees Fahrenheit (F). The air conditioners in residents' rooms were still not functioning. According to the [U.S. FOI] prior to the transfer of residents from the other floors on [NJ Ex Order 26.4(b)(1)], he took a temperature on the 3rd floor unit at 2 PM ,which indicated 76 degrees Fahrenheit (F). (Normal temperature ranges is from 71 F-81 F degree). According to the Environmental Temperature Log (ETL) for the 3rd floor on [NJ Ex Order 26.4(b)(1)], the temperatures at 11 AM was documented at 76 degrees F and at 2 PM the temperature was documented at 78 degrees F. There were no specific locations correlated to each temperature taken on the ETL. The surveyor was also provided a copy of the [U.S. FOIA (b) (6)] ETL for the 3rd floor. The ETL for the 3rd floor on [NJ Ex Order 26.4(b)(1)] at 2 PM and 5 PM temperatures were both documented at 76 degrees. On [NJ Ex Order 26.4(b)(1)], the following temperatures were documented : 11 AM 76 degrees F; 2 PM 78 degrees F and at 5 PM 79 degrees F. There were no specific locations correlated to each temperature taken on the ETL. Also, the Surveyor confirmed with the	F 921	conditioning units to alleviate the issue. Element 2- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. In cases when heating or air conditioning system fails, some or all of our residents 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 will not recur. The Maintenance Director or his designee will do a daily environmental temperature log randomly on each units. The maintenance log book will be checked daily by the Maintenance Director or his designee for any request for HVAC repair and immediately resolve the issue. Element 4- How the corrective actions will be monitored to ensure that the deficient practice will not recur. The results of the Environmental Temperature Log and/or completion of HVAC request for repair will be reviewed by the Administrator weekly. Subsequently, the results will be presented to the Quality Assurance Committee for that meets quarterly for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. BUILDING _____ B. WING _____	C 08/30/2024

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

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F 921		F 921		

Continued From page 2

U.S. FOIA (b) (6) that there were no more temperatures taken after 5 PM on NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) on the 3rd floor.

On 8/28/2024, the U.S. FO was told by the U.S. FOIA (b) (6) that residents were complaining of being warm, so he deployed an additional 3 portable air conditioners and electric fans to residents' rooms and placed a Commercial electric fan in the hallway.

On 08/29/24 at 12:15 PM, the Surveyor interviewed Resident #2 who stated, that he/she was placed on NJ Ex Order 26.4b1 and confirmed that the room air conditioner was not working and was proved a fan, but the room was still "hot". The resident couldn't provide the surveyor with a time or date regarding the temperature.

On 08/29/24 at 3:19 PM, the surveyor interviewed Resident #3's daughter who stated, air conditioner was not working in Resident #3 room, but an electric fan was provided.

NJAC 8:39-31.2(e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060910	A. BUILDING: _____ B. WING _____	C 08/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Complaint #: NJ00176536 , NJ00176590 Census: 134 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 3 of 14-day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	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 .	8/30/24

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

Electronically Signed | 10/01/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060910	A. BUILDING: _____ B. WING _____	C 08/30/2024

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

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and 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 CNA and perform CNA duties. The surveyor requested staffing for the weeks of 08/11/2024 to 08/24/2024, the facility was deficient in CNA staffing for residents on 3 of 14-day shifts, as follows: -08/11/24 had 16 CNAs for 134 residents on the day shift, required at least 17 CNAs. -08/17/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -08/18/24 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs.	S 560	All the residents have the potential to be affected by the staffing shortage at any given day or shift. Element 3- What measures will be put 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 (8/11/24; 8/17/24 and 8/18/24). This facility has hired 2 (two) new full-time and 1 (one) part-time CNAs to assist in satisfying the staffing needs. Optimacare Castle Hill will continue to utilize staffing agencies to fill in the open slots. Likewise, overtime and bonus incentives will continue to be offered to our 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 Director of Nursing (DON) and/or her designee will review staffing daily completed by the staffing coordinator for adequacy and compliance with the staffing regulations.	
S2150	8:39-31.2(e) Mandatory Physical Environment (e) The facility shall be kept in good repair and maintained without harm or jeopardy to residents.	S2150		8/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060910	A. BUILDING: _____ B. WING _____	C 08/30/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S2150	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of documentation, the facility failed to consistently maintain a functional Heating, Ventilation and Air Condition Unit (HVAC) in good repair on 1 of 3 nursing units (3rd floor) in order to maintain a comfortable environment for its residents, staff, and visitors . This deficient practice was evident by the following: On 08/29/24, at 10:30 am., the surveyor conducted a tour of an empty 3rd floor unit with the Administrator (ADM) and Maintenance Director (MD). According to the ADM, a decision was made to utilize the 3rd floor unit to accommodate isolation for NJ Ex Order 26.4(b)(1) residents and NJ Ex Order 26.4(b)(1) The NJ Ex Order 26.4(b)(1) residents and NJ were housed on this unit from NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1). During the tour, the ADM stated that 3rd floor unit had been closed for over one year and the air conditioning units were not working. The decision was made to transfer the NJ Ex Order 26.4(b)(1) residents to this floor on NJ Ex Order 26.4(b)(1). The MD stated that the 3rd floor was not on his daily maintenance rounds inspections. The surveyor observed there were no residents on the floor during the tour. The thermostat on the wall indicated 74 degrees Fahrenheit (F). The air conditioners in residents' rooms were still not functioning.	S2150	Element 1 - How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. All residents that were temporarily moved to the 3rd floor on NJ Ex Order 26.4(and NJ Ex Order 26.4(to accommodate NJ Ex Order 26.4(b)(1) plus NJ Ex Order 26.4(b)(1) that require NJ Ex Order 26.4(were altogether moved out of the 3rd floor on NJ Ex Order 26.4 at approximately 8:00 PM to a different unit with more acceptable room temperature. While on the 3rd floor unit, Resident # 2 and Resident #3 were provided with an electric fan AND a portable air conditioning units to alleviate the issue. Element 2- How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. In cases when heating or air conditioning system fails, some or all of our residents 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 will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060910	A. BUILDING: _____ B. WING _____	C 08/30/2024

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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S2150	Continued From page 3 According to the MD, prior to the transfer of residents from the other floors on [NJ Ex Order 26.4(b)(1)], he took a temperature on the 3rd floor unit at 2 PM ,which indicated 76 degrees Fahrenheit (F). (Normal temperature ranges is from 71 F-81 F degree). According to the Environmental Temperature Log (ETL) for the 3rd floor on [NJ Ex Order 26.4b1], the temperatures at 11 AM was documented at 76 degrees F and at 2 PM the temperature was documented at 78 degrees F. There were no specific locations correlated to each temperature taken on the ETL. The surveyor was also provided a copy of the Administrator's ETL for the 3rd floor. The ETL for the 3rd floor on [NJ Ex Order 26.4(b)(1] at 2 PM and 5 PM temperatures were both documented at 76 degrees. On [NJ Ex Order 26.4(b)(1] the following temperatures were documented : 11 AM 76 degrees F; 2 PM 78 degrees F and at 5 PM 79 degrees F. There were no specific locations correlated to each temperature taken on the ETL. Also, the Surveyor confirmed with the Administrator that there were no more temperatures taken after 5 PM on [NJ Ex Order 26.] and [NJ Ex Order 26.4(b)(1] on the 3rd floor. On 8/28/2024, the MD was told by the Administrator that residents were complaining of being warm, so he deployed an additional 3 portable air conditioners and electric fans to residents' rooms and placed a Commercial electric fan in the hallway.	S2150	The Maintenance Director or his designee will do a daily environmental temperature log randomly on each units. The maintenance log book will be checked daily by the Maintenance Director or his designee for any request for HVAC repair and immediately resolve the issue. Element 4- How the corrective actions will be monitored to ensure that the deficient practice will not recur. The results of the Environmental Temperature Log and/or completion of HVAC request for repair will be reviewed by the Administrator weekly. Subsequently, the results will be presented to the Quality Assurance Committee for that meets quarterly for review and recommendations.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315344 Y1	A. Building B. Wing Y2	10/7/2024 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 F0921	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/30/2024	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	
8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060910 Y1	A. Building B. Wing Y2	10/7/2024 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 S2150	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-31.2(e)	Completed	Reg. #	Completed
LSC	08/30/2024	LSC	08/30/2024	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	
8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO