STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE FOUNTAINS	**505 COUNTY AVENUE SECAUCUS, NJ 07094**

(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 #: NJ00163659 and NJ00164821 Census: 263 Sample Size: 4 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		11/13/23

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

Electronically Signed | 10/30/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING _____ B. WING _____	C 10/17/2023

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OPTIMA CARE FOUNTAINS	**505 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 842	Continued From page 1	F 842		

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE FOUNTAINS	**505 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 842	Continued From page 2 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #: NJ000163659 and NJ000164821 Based on interviews, and record review, as well as review of pertinent facility documentation on 10/17/23, it was determined that the facility failed to consistently implement their policy on Charting and Documentation for 2 of 4 residents (Resident #1 and #2) reviewed for documentation. This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Resident #1 was admitted to the facility on [redacted], with a diagnosis that included but was not limited to [redacted]. The Minimum Data Set (MDS) an assessment tool dated [redacted], Resident #1's [redacted] and required [redacted] from staff with Activities of Daily Living (ADLs). The Care Plan (CP) revised 8/16/23, indicated that Resident #1 had the potential for [redacted] The "Documentation Survey Report" (DSR) for [redacted], and the progress notes (PN) indicated no documented evidence that the care was provided by the staff on the following dates and shifts which was not according to their policy: On [redacted]: During the 7:00 a.m. - 3:00 p.m. shift on [redacted] During the 11:00 p.m. - 7:00 a.m. shift on [redacted]	F 842	1. There was no change in condition for resident #1 as a result of this deficient practice. Resident #2 is no longer in the facility. 2. All residents have the potential to be affected by this deficient practice. 3. All CNAs will be in serviced on ADL documentation by the nurse educator. An audit tool was created for nurse managers and nursing supervisors to track ADL documentation at the end of each shift. 4. The results of the audits will be reviewed at the monthly QAPI meeting for three months and follow up action taken if necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE FOUNTAINS	**505 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 842	Continued From page 3 [redacted], and [redacted] 2. According to the AR, Resident #2 was admitted to the facility on [redacted] and was discharged on [redacted], with diagnoses that included but were not limited to: [redacted] In the MDS dated [redacted], Resident #2's [redacted] and needed assistance from staff with ADLs. The DSR and the PNs from [redacted] to [redacted] showed no documented evidence completed by the staff that Resident #2's ADL was provided on the following dates and shifts which was not according to their policy. On [redacted]: During the 7:00 a.m. - 3:00 p.m. shift on [redacted] During the 3:00 p.m. - 11:00 p.m. shift on [redacted] During the 11:00 p.m. - 7:00 a.m. shift on [redacted], and [redacted] [redacted] an interview with Certified Nursing Assistant (CNA #1 and CNA #2) on 10/17/23 from 12:15 p.m. to 12:28 p.m. The [redacted] stated that they were responsible for documenting the ADL care provided in the [redacted]), (a mobile-enabled app that runs on wall-mounted kiosks or mobile devices that enables care staff to document activities of daily living at or near the point of care to help improve accuracy and timeliness of documentation). The [redacted] further stated that they would document even if the care was not provided due to refusal. They both explained that the documentation must	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING _____ B. WING _____	C 10/17/2023

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OPTIMA CARE FOUNTAINS	**505 COUNTY AVENUE SECAUCUS, NJ 07094**

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F 842	Continued From page 4 be completed in the residents' DSR by the end of each shift to show that the care was provided to the residents. The surveyor conducted an interview with the Unit Managers (UM #1) on 10/17/23 at 2:17 p.m. The UM #1 stated that residents were provided care every day and that the [redacted] are required to document in the [redacted] at the end of each shift that the care was provided to the residents and the [redacted] should ensure that the [redacted] required documentation was implemented at the end of the shift. The Job Description for CNA, undated, indicated "...to follow all facility policies related to administering care to residents...record all documentation on flow sheets and electronic medical record..." The Job Description for UM, undated, showed "To function at a professional nursing level using both administrative leadership and clinical expertise in order to assure the comprehensive care and treatment is rendered to the resident population, collaborates with the interdisciplinary team in the design, implementation, and evaluation of various programs within the unit. Twenty-four-hour responsibility for the continuity of nursing care and the management of the resident welfare...6. Encourages nursing staff to perform their jobs to the fullest of their potential; 7. Provides professional guidance and supervision to both professional and nonprofessional unit staff..." The facility's policy titled "Charting and Documentation" dated on 11/2/21, showed "All services provided to the resident, or any changes in the resident's medical or mental condition, shall	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 5 be documented in the resident's medical record...Documentation of procedures and treatments shall include care-specific details and shall include at a minimum: a. The date and time the procedure/treatment was provided, b. The name and title of the individual(s) who provided the care c. The assessment data and/or any unusual findings obtained during the procedure/treatment e. Whether the resident refused the procedure/treatment..." NJAC 8:39-27.1(b)	F 842		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60918	A. BUILDING: _____ B. WING _____	C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE FOUNTAINS	505 COUNTY AVENUE SECAUCUS, NJ 07094

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S 000	Initial Comments Complaint #: NJ00163659 and NJ00164821 Census: 263 Sample Size: 4 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 the facility document review, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios mandated by the state of New Jersey. This deficient practice had the potential to affect all residents. Findings include:	S 560	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. The staffing coordinators will continue to utilize agency staff to fill open CNA shifts on the schedule to maintain the	11/13/23

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

Electronically Signed | 10/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60918	A. BUILDING: _____ B. WING _____	C 10/17/2023

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OPTIMA CARE FOUNTAINS	505 COUNTY AVENUE SECAUCUS, NJ 07094

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 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. For the 2 weeks of Complaint staffing from 04/16/2023 to 04/29/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -04/17/23 had 29 CNAs for 263 residents on the day shift, which required at least 33 CNAs. -04/18/23 had 31 CNAs for 263 residents on the day shift, which required at least 33 CNAs. -04/19/23 had 31 CNAs for 263 residents on the day shift, which required at least 33 CNAs. -04/20/23 had 30 CNAs for 263 residents on the day shift, which required at least 33 CNAs. -04/21/23 had 32 CNAs for 269 residents on the day shift, which required at least 34 CNAs. -04/22/23 had 31 CNAs for 265 residents on the day shift, which required at least 33 CNAs.	S 560	minimum staff to resident ratios. Recruitment will continue to hire new CNAs. The Director of Nursing and ADONs will review the staffing schedule on an ongoing basis. 4. CNA staffing levels will be reviewed at the monthly QAPI meeting for three months and follow up action taken if necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 -04/23/23 had 32 CNAs for 264 residents on the day shift, which required at least 33 CNAs. -04/24/23 had 27 CNAs for 264 residents on the day shift, which required at least 33 CNAs. -04/25/23 had 27 CNAs for 264 residents on the day shift, which required at least 33 CNAs. -04/26/23 had 30 CNAs for 264 residents on the day shift, which required at least 33 CNAs. -04/27/23 had 29 CNAs for 264 residents on the day shift, which required at least 33 CNAs. -04/28/23 had 32 CNAs for 264 residents on the day shift, which required at least 33 CNAs. -04/29/23 had 31 CNAs for 269 residents on the day shift, which required at least 34 CNAs. For the 2 weeks of Complaint staffing from 05/28/2023 to 06/10/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -05/28/23 had 33 CNAs for 274 residents on the day shift, which required at least 34 CNAs. -06/01/23 had 32 CNAs for 272 residents on the day shift, which required at least 34 CNAs. -06/02/23 had 33 CNAs for 272 residents on the day shift, which required at least 34 CNAs. -06/04/23 had 28 CNAs for 272 residents on the day shift, which required at least 34 CNAs. -06/05/23 had 32 CNAs for 273 residents on the day shift, which required at least 34 CNAs. -06/10/23 had 31 CNAs for 277 residents on the day shift, which required at least 35 CNAs. For the 2 weeks of Complaint staffing from 10/01/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -10/01/23 had 27 CNAs for 262 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 day shift, which required at least 33 CNAs. -10/02/23 had 28 CNAs for 262 residents on the day shift, which required at least 33 CNAs. -10/05/23 had 32 CNAs for 262 residents on the day shift, which required at least 33 CNAs. -10/06/23 had 32 CNAs for 262 residents on the day shift, which required at least 33 CNAs. -10/07/23 had 31 CNAs for 260 residents on the day shift, which required at least 32 CNAs. -10/08/23 had 30 CNAs for 260 residents on the day shift, which required at least 32 CNAs. -10/09/23 had 31 CNAs for 260 residents on the day shift, which required at least 32 CNAs.	S 560		

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
315476 (Y1)	A. Building B. Wing (Y2)	12/4/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE FOUNTAINS	505 COUNTY AVENUE SECAUCUS, NJ 07094

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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 11/13/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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
10/17/2023

☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
60918		12/4/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE FOUNTAINS	505 COUNTY AVENUE SECAUCUS, NJ 07094

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/13/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
10/17/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO