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 10/17/2024

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 #'s:NJ166113, NJ166137, NJ166809, NJ170019, NJ172459, NJ175436, NJ176328, NJ176501, NJ176722, NJ177353, NJ177725, and NJ178658 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found to not be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 10/14/24 through 10/17/24. Survey Census: 277 Sample Size: 45 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 RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		12/5/24

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

Electronically Signed | 11/08/2024

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 10/17/2024

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 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and record review, the facility failed to ensure one of 45 (Resident (R) 26) sampled residents observed while dining were treated with dignity. Specifically, staff failed to NJ Exec Order 26.4b1 R265. This failure had the potential to cause residents to feel undignified. Findings include:	F 550	1. Resident R265 was assessed by the US FOIA (b)(6) on NJ Exec Order 26.4b1 to determine if Resident R265 sustained a NJ Exec Order 26.4b1 from CNA 15 standing over them while assisting them with their meal. NJ Exec Order 26.4b1 was identified. CNA 15 was re-educated by the Staff Educator on 10/15/2024 on resident rights	

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 10/17/2024

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 550	Continued From page 2 Review of the facility's policy titled, "Promoting/Maintaining Resident Dignity," revised 07/2023, revealed, ". . . It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . . ." Review of R265's "Admission Record," found in the electronic medical record (EMR) "Profile" tab, showed a facility admission date of NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 . Review of R265's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b and located under the "MDS" tab of the EMR, revealed R265 required NJ Exec Order 26.4b . It was recorded that R265 was NJ Exec Order 26.4b1 During an observation on 10/14/24 at 12:04 PM in the dining hall, R265 was observed in the dining room NJ Exec Order 26.4b1 the noon meal. Certified Nursing Assistant (CNA) 15 was standing over R 265 NJ Exec Order 26.4b1 . At 12:11 PM, Registered Nurse Supervisor (RNS1) walked up to CNA15 and spoke with her. At this time, CNA15 sat down and continued to NJ Exec Order 26.4b1 . During an interview on 10/14/24 at 12:17 PM, RNS1 stated that CNA 15 "is a very good worker and knows better than to stand over a resident	F 550	specific to maintaining and promoting dignity. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all nursing staff on the facility's policy of Promoting and Maintaining Dignity during meals on 11/1/2024. A dining audit of (20) meals will be conducted by the Director of Nursing and/or designee weekly for (4) weeks, or until 100% compliance, to ensure staff are maintaining and promoting resident dignity during meals. 4. The Director of Nursing/designee will review the audit results to determine if staff are maintaining and promoting resident dignity during meals. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Director of Nursing will be responsible for ensuring compliance.	

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 10/17/2024

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 550	Continued From page 3 NJ Exec Order 26.4b1 ." NJAC 8:39-4.1(A)	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State	F 583		12/5/24

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 10/17/2024

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 583	Continued From page 4 law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure personal privacy during care for two of 47 (Resident (R) 75 and R110) residents observed. This had the potential to cause NJ Exec Order 26.4b1 or NJ Exec Order 26 for the residents. Findings include: Review of the facility's policy titled, "Resident Privacy and Confidentiality," dated 07/2023, revealed, ". . . During the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts . . ." 1. Review of R75's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R75 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 Review of R75's significant change "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1, revealed R75 had a "Brief Interview for Mental Status (BIMS)" score of NJ Exe out of 15, which indicated he had NJ Exec Order 26.4b1 During an observation on 10/14/24 at 2:19 PM, Certified Nursing Assistant (CNA) 20 and Quality Assurance (QA)/CNA 3 were in R75's room, and the door was closed. CNA20 opened R75's door.	F 583	1. Residents R75 and R110 were assessed by the NJ Exec Order 26.4b1 Director/designee on NJ Exec Order 26.4b1 to determine if Resident R75 and R110 sustained a NJ Exec Order 26.4b1 from CNA 20 and CNA 3 not ensuring them with personal privacy when personal care was being provided. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was identified. CNA 20 and CNA 3 were re-educated by the Staff Educator on 11/5/2024 on resident rights specific to maintaining and promoting personal privacy. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all nursing staff on the facility's policy of Resident Privacy and Confidentiality on 11/5/2024. A resident's rights audit of (20) staff will be conducted by the Director of Nursing and/or designee weekly for (4) weeks, or until 100% compliance, to ensure staff are maintaining and promoting resident privacy when providing personal care. 4. The Director of Nursing/designee will review the audit results to determine if staff are maintaining and promoting resident privacy when providing personal care.	

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 10/17/2024

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 583	Continued From page 5 When the door was opened, R75's NJ Exec Order 26.4b1 and could be seen from the hall. CNA20 yelled for Unit Manager (UM) 1 to bring the resident's NJ Exec Order 2 to the room, calling the resident by name. UM1 entered the room, leaving the door open, provided the resident's NJ Exec Order 26 and then left the room, shutting the door. 2. Review of R110's "Admission Record," located under the "Profile" tab of the EMR, revealed R110 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including NJ Exec Order 26.4b1 . Review of R110's quarterly "MDS," with an ARD of NJ Exec Order 26.4b1 and located under the "MDS" tab of the EMR, revealed R110 had a "BIMS" score of NJ Exe out of 15, which indicated the resident was NJ Exec Order 26.4b1 . During an observation on 10/14/24 at 3:01 PM, CNA20 and QA/CNA 3 were in R110's room, and the door was closed. CNA20 opened R110's door. When the door was opened, R110's NJ Exec Order 26 and could be seen from the hall. CNA20 left the room and did not close the door. CNA20 returned to R110's room and did not close the door. R110 NJ Exec Order 26.4b1 as CNA20 and QA/CNA3 resumed providing personal care. Registered Nurse (RN) 1 passed the room and immediately shut the door. During an interview on 10/14/24 at 3:30 PM, QA/CNA3 and CNA 20 stated they were not aware they had left R75 and R110's doors open, NJ Exec Order 26.4b1 both residents. They confirmed both residents' privacy was compromised. During an interview on 10/14/24 at 4:00 PM, RN1	F 583	The results of the audits will be reported to the facility's quarterly Quality Assurance and Performance Improvement committee to identify trends and concerns. The Director of Nursing will be responsible for ensuring compliance.	

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 10/17/2024

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 583	Continued From page 6 confirmed the door to R110's room had been open, and she could tell [redacted] was [redacted] RN1 stated that was why she immediately closed the door. RN1 stated she had not talked with the CNAs as they had left their shift.	F 583		
F 584 SS=D	NJAC 8:39-4.1(a) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each	F 584		12/5/24

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 10/17/2024

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 584	Continued From page 7 resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure one of one public bathrooms (Unit 12 public bathroom) observed for concerns was free of insects and was maintained in a sanitary manner. This had the potential to cause the spread of infection by disease-causing organisms. Findings include: Review of the facility's policy titled, "Resident Environment," dated 09/2022, revealed, ". . . Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior . . ." During an interview on10/16/24 at 12:55 PM, the US FOIA (b)(6)) stated the facility's pest management company came every two weeks and sprayed to prevent insects for the entire campus. US FOIA (b)(6) stated this treatment would take two days to complete, and if there were any issues with pests, it would be documented at each nurses' station which areas might require attention. Review of the facility's pest control	F 584	1. The facility scheduled an emergency pest control visit from their licensed provider to treat the restroom and any nearby areas. A deep cleaning of the restroom was conducted, and all cracks were repaired, floor tiles replaced, and walls were painted. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all staff on recognizing signs of insect activity, the importance of maintaining high sanitation standards in and around restrooms and to inform maintenance timely if insects are sighted and and when repairs are needed on 11/5/2024. An audit of all public restrooms will be conducted by the Director of Nursing and/or designee weekly for (8) weeks, or	

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 10/17/2024

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 584	Continued From page 8 sheets for September 2024 revealed no documentation of roaches on Unit 12. During a confidential interview on 10/16/24 at 4:35 PM, a family member stated there were roaches in the public bathroom on Unit 12 across from the dayroom. The family member stated the roaches had been seen on more than one occasion. The family member stated the bathroom was in disrepair, with the paint peeling, the wall around the window crumbling, and the floor with missing tiles. On 10/16/24 at 4:45 PM, the surveyor prepared to complete an observation of the public bathroom on Unit 12. An unidentified resident stated, "Oh there's roaches in there." When the door to the bathroom was opened, a roach ran across the floor from under the sink to behind the toilet. Inside the bathroom, it was observed that the wall by the heating unit had crumbling plaster and peeling paint, the heater unit had peeling paint, and there were missing tiles around the back of the toilet. During an interview on 10/16/24 at 6:32 PM, US FOIA (b)(6) stated there had been no reports of roaches in the bathroom. They agreed that the bathroom needed repairs.	F 584	until there is 100% compliance, to ensure there are no signs of insects and that they are being maintained in a safe, clean and comfortable manner. 4. The Director of Housekeeping/designee will review the audit results to determine that there are no signs of insects in the public restrooms and that they are being maintained in a safe, clean and comfortable manner. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Director of Housekeeping will be responsible for ensuring compliance.	
F 585 SS=E	NJAC 8:39-31.4(a) Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585		12/5/24

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 10/17/2024

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 585	Continued From page 9	F 585		

that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may

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 10/17/2024

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 585	Continued From page 10 be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation	F 585		

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 10/17/2024

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 585	Continued From page 11 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and facility policy review, the facility failed to provide information on how to file an anonymous grievance for seven of seven residents (Residents (R) 23, R44, R117, R140, R152, R177, and R200) reviewed for the grievance process out of a total sample of 45. The failure had the potential to affect residents' ability to safely report concerns without fear of retaliation. Findings include: Review of the facility's policy titled, "Resident and Family Grievances," revised 10/16/24, revealed, ". . . It is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination or reprisal . . . A grievance may be filed anonymously. Anonymous grievance may be filed using the Compliance Hotline and/or complaint/grievance boxes located throughout the facility . . ." During the initial tour of the facility, a poster recording the number for the facility's Compliance Hotline was observed posted near the administrative office. No complaint/grievance	F 585	1. The facility ordered grievance boxes to be conspicuously installed throughout the facility. A resident council meeting was held to review the facility's grievance policy and to inform the residents that they can use the grievance boxes should they wish to file an anonymous grievance. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. All residents will be informed of the facility's grievance policy upon admission, including the location of the grievance boxes should they wish to file an anonymous grievance. A review of the facility's grievance policy will be conducted quarterly at the facility's Resident Council meeting. 4. A visual audit of all grievance boxes will be conducted by the Administrator and/or designee monthly for (3) months to	

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 10/17/2024

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 585	Continued From page 12 boxes were observed in the facility. During a group interview on 10/15/24 at 2:00 PM, R23, R44, R117, R140 R152, R177, and R200 all stated that they were not aware of the ability to file anonymous complaints. The residents stated they were not aware of the compliance hotline, where to find the number for the compliance hotline, or of any grievance boxes in the facility. Review of the Resident Council monthly meeting minutes, dated October 2023 through August 2024, revealed no documentation residents had been provided information related to making anonymous complaints or filing grievances anonymously. During an interview on 10/15/24 at 3:00 PM, the US FOIA (b)(6) confirmed that there were no grievance boxes at the facility for residents to use to make anonymous complaints. The US FOIA (b)(6) stated that the Compliance Hotline number was posted for everyone to see. When asked if the anonymous complaint process had been reviewed with residents at group meetings, both confirmed that they had not done that. NJAC 4.1 (a)35 NJAC 8:39-13.2(c)	F 585	ensure the grievance boxes are in place. A quarterly audit of the Resident Council meeting minutes will be conducted to ensure the facility's grievance policy is being reviewed. The Recreation Director will review the audit results to determine if the facility is appropriately communicating to residents how to file an anonymous grievance and that a process to do is is being maintained. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Recreation Director will be responsible for ensuring compliance.	
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		12/5/24

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 10/17/2024

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 600	Continued From page 13 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews, record review, review of facility reported incidents (FRI), and review of facility policy, the facility failed to protect the residents' right to be free from NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1 for five (Resident (R) 262, R426, R424, R66, and R128) of eight residents reviewed for NJ Exec Order 2 out of a total sample of 45 residents. R262 NJ Exec Order 26.4b1 R76 on the NJ Exec O with a NJ Exec Order 26.4b1; R426 NJ Exec Order R424's NJ Exec O and R140 NJ Exec Order R142, R66, and R128 with NJ Exec Order 26.4b1. The facility's failure to protect residents from NJ Exec Order 2 placed resident at continued risk of NJ Exec Order Findings include: Review of the facility's policy titled, "Abuse, Neglect and Exploitation," reviewed 07/2024, indicated, "It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." 1. a. Review of R262's "Admission Record," located under the "Profile" tab in the electronic medical	F 600	1. Residents R140, R142, R66, R262, R76 and R128 were assessed by the US FOIA (b)(6) on NJ Exec Order 26.4b1 for any delayed NJ Exec Order 26.4b1 due to their involvement in these NJ Exec Order 26.4b1 No NJ Exec Order 26.4b1 were identified. Residents R424 and R426 no longer reside in the facility. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all staff on the facility's policy of Abuse, Neglect and Misappropriation of Resident Property on 11/6/2024. An audit of all resident-to-resident incidents will be conducted by the Administrator/designee for (3) months, or until 100% compliance, to ensure the facility is appropriately protecting their residents. 4. The Administrator/designee with review	

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 10/17/2024

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 600	Continued From page 14 record (EMR), indicated that R262 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including NJ Exec Order 26.4b1 . Review of R262's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 and located under the "MDS" tab in the EMR, revealed R262 had a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Order 26.4b1 out of 15, which indicated R262 was NJ Exec Order 26.4b1 b. Review of R76's "Admission Record," located under the "Profile" tab in the EMR, indicated that R76 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including NJ Exec Order 26.4b1 Review of R76's quarterly "MDS," with an ARD of NJ Exec Order 26.4b1 and located under the "MDS" tab of the EMR, indicated a "BIMS" of NJ Exec Order 26.4b1 out of 15, which indicated R76 was NJ Exec Order 26.4b1 . Review of a facility provided "Long-term Care (LTC) Reportable Event Survey (initial reporting)," dated NJ Exec Order 26.4b1 , indicated, ". . . Date of Event: NJ Exec Order 26.4b1 at 3:30 PM, significant event, called in on NJ Exec Order 26.4b1 at 7:50 PM . . . Type of incident: NJ Exec Order 26.4b1 . . ." Review of a facility provided "Privileged and Confidential Quality Assurance (QA) Document," dated NJ Exec Order 26.4b1 , indicated, ". . . At 3:30 PM, [R262] NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 went four times to [R76]'s NJ Exec Order 26.4b1 and [R76] said to [R262] NJ Exec Order 26.4b1 and [R262] NJ Exec Order 26.4b1 [sic] on [R76]'s NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 noted. Noted NJ Exec Order 26.4b1 under NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 .	F 600	the results of the audits to determine if the facility is appropriately protecting their residents. The results of these audits will be reported to the facility's quarterly Quality Assurance and Performance Improvement committee to identify trends and concerns. The Administrator will be responsible for ensuring compliance.	

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 10/17/2024

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 600	Continued From page 15	F 600		

Immediate Action Taken: NJ Exec Order 26.4b1 , physician and families notified . . ."

Review of the facility provided "Concern Investigation (5-day summary)," dated NJ Exec Order 26.4b1, indicated, "On NJ Exec Order 26.4b1, at approximately 7:30 PM, the US FOIA (b)(6) informed the facility that our residents ([R76] and [R262]) were involved in NJ Exec Order 26.4b1 in which [R262] NJ Exec Order 26.4b1 [R76]'s NJ Exec O with NJ Exec residents were immediately NJ Exec Order 26.4b1 . [R76] NJ Exec Order 26.4b1 on NJ Exec Order 26.4b and [R262] with NJ Exec Order 26.4b1 . Both residents NJ Exec Order 26 any NJ Exec O upon nurses' assessment and interview. Their emergency contacts made aware, and the incident was reported to [name of state] Department of Health (NJDOH). Upon investigation, according to staff, [R76] an NJ Exec Order 26.4b1 with BIMS score of NJ Exe and able to make NJ Exec Order 26.4b1 , and NJ Exec Order 26 with all NJ Exec activities of daily living (ADL)'s and NJ Exec Order 26.4b1 on the unit, reported to staff that NJ Exec Order 26.4b [R262] NJ Exec Order 26.4b1 [R262] became NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with a NJ Exec Orde that NJ Exec Order 26.4b1 . [R76] NJ Exec Order 26.4b1 . Staff ensured that both NJ Exec Order 26.4b1 and called the US FOIA (b)(6). [R76] was educated and encouraged to always call staff to intervene with any issue NJ Exec O has with NJ Exec Order 26.4b to prevent further NJ Exec Order 26.4b1 . NJ Exec O NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 and every

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 10/17/2024

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 600	Continued From page 16	F 600		

NJ Exec Order 26.4b1 [redacted]. [R262] on the other hand NJ Exec Order 26.4b1 [redacted] with BIMS score of [redacted] with NJ Exec Order 26.4b1 [redacted] on the unit apparently went in to [R76]'s NJ Exec Order 26.4b1 and when [R76] asked [redacted] to NJ Exec Order 26.4b1 [redacted], may be thinking NJ Exec Order 26.4b1 and another person asking NJ Exec Order 26.4b1. Hence, [redacted] [meaning R262] [redacted] [R76]. [R262], who is currently on every NJ Exec Order 26.4b1 was seen by staff in NJ Exec Order 26.4b1 [redacted] about 10 minutes before [R76] reported the incident. Upon nurse's assessment, [R262] NJ Exec Order 26.4b1 and [redacted]. [redacted] was NJ Exec Order 26.4b1 and [redacted] to an area with high staff [redacted] consultants for further evaluation requested for both residents. [redacted] initiated [R76] for three days for safety, and [R262] continues an ongoing every NJ Exec Order 26.4b1. Staff will ensure that [redacted] in common shared areas and activities.
Management re-adjusted the rooming by moving [R262] to the [redacted] floor of the unit for more [redacted] and will ensure to NJ Exec Order 26.4b1 to the new room to prevent [redacted] and further incident occurrence NJ Exec Order 26.4b1 was initiated for [R76] without any changes in [redacted] Social workers will follow up with them to ensure their safety and well-being.
Intervention: Emergency contacts made aware of the incident, involved resident were maintained separated, staff will continue to [redacted] from each other in common

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 10/17/2024

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 600	Continued From page 17	F 600		

shared areas and activities whenever possible, social worker will continue to follow up the involved residents to ensure their safety and well-being, management re-adjusted rooming to separate both residents' rooms and NJ Exec Order 26.4b [redacted] for [R262], NJ Exec Order 26.4b1 consult in place for further evaluation for both residents and [R262] medication adjusted as per NJ Exec Order 26.4b1 recommendation, and NJ Exec Order 26.4b1 and every NJ Ex [redacted] in place for three days for [R76]. Conclusion: From investigation, interviews, and review of records, both [R76] and [R262] have NJ Exec Order 26.4b1 diagnosis but have not been in any NJ Exec Order 26.4b1 with each other and NJ Exec Orde [redacted]. Hence, NJ Exec Order F [redacted] is ruled out in this incident. [R76] was educated and encouraged to NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 to staff so that appropriate interventions can be put in place to prevent incidents such as this and NJ Exec Order 26.4b1 [redacted]. Both residents are currently followed by an in-house NJ Exec Order 26.4b1 and maintained on NJ Exec Order 26.4b1 medication and [R262] medication adjusted as per NJ Exec Order 26.4b1 recommendation. Social workers will continue to follow both residents to ensure their safety and well-being."

Review of a facility provided "Employee Statement" for Licensed Practical Nurse (LPN) 3, dated NJ Exec Order 26.4b1 [redacted], indicated, "At 3:30 PM, [R76] reported that [R262] NJ Exec Order 26.4b1 and [R76] said to [R262] NJ Exec Order 26.4b1 x four. [R262] NJ Exec Order 26.4b1 and NJ Exec Orde [R76]'s NJ Exec Orde and NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 [redacted], NJ Exec Order 26.4b1 [redacted]. No complaint of NJ Exec On NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 Applied NJ Exec Order 26.4b1. Notified supervisor, both families and physician. [R76]'s family did not respond, so left a message.

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 10/17/2024

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 600	Continued From page 18 Separated both residents, NJ Exec Order 26.4b1 for [R262], and NJ Exec Order 26.4b1 for [R76]." On 10/16/24 at 9:18 AM, an attempt to contact LPN3 was made, and a voice message was left. No return phone call was received by the end of survey. During an interview on 10/15/24 at 4:15 PM, the US FOIA (b)(6) that this incident was a misunderstanding of someone NJ Exec Order 26.4b1 because R262 went into a NJ Exec Order 26.4b1. 2. a. Review of R426's "Admission Record," located under the "Profile" tab in the EMR, indicated R426 was re-admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including NJ Exec Order 26.4b1 b. Review of R424's "Admission Record," located under the "Profile" tab in the EMR, indicated that R424 was re-admitted to the facility on NJ Exec Order 26.4b1 diagnoses including NJ Exec Order 26 Review of a facility provided "Reportable Event Record/Report (initial report)," dated NJ Exec Order 26.4b1, indicated, "Date of Event: NJ Exec Order 26.4b1, time of event: 5:10 PM . . . Was significant event called in: yes, Date: NJ Exec Order 26.4b1, and time: 10:30 AM . . . Type of incident: NJ Exec Order 26.4b1 . . . On NJ Exec Order 26.4b1, at approximately 5:10 PM, the US FOIA (b)(6) informed the facility that our residents ([R426] and [R424]) were involved in NJ Exec Order 26.4b1 in which [R426] NJ Exec Order [R424] on NJ Exec Order 26.4. The incident was witnessed by US FOIA (b)(6) and the US FOIA (b)(6)) NJ Exec Order 26.4b1 [R424]. The	F 600		

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 10/17/2024

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 600	Continued From page 19	F 600		

aide was NJ Exec Order 26.4b1 because [R426] was NJ Exec O They were NJ Exec Order 26.4b1 for safety. NJ Exec Order 26.4b1 noted on both residents. Emergency contacts made aware, and incident called in to [name of state] Department of Health (NJDOH) . . . Interventions: Both residents NJ Exec Order 26.4b1, nurse's assessment for NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 initiated for [R424], NJ Exec Order consult for further evaluation for both residents, social workers follow up to ensure residents safety and well-being, staff will continue to ensure both residents NJ Exec Order 26.4b1 in common shared areas and activities, and emotional support provided."

Review of a facility provided "Concern Investigation (5-day summary)," dated NJ Exec Order 26.4b1 indicated, "On NJ Exec Order 26.4b1, at approximately 5:10 PM, the US FOIA (b)(6) informed the facility that our residents ([R426] and [R424]) were involved in NJ Exec Order 26.4b1 in which [R426] NJ Exec Order [R424] on NJ Exec Order 26.4. The incident was witnessed by US FOIA (b)(6) NJ Exec Order 26.4b1 [R424]. The aide was NJ Exec Order 26.4b1 because [R426] was NJ Exec O They were both NJ Exec Order 26.4b1 for safety. NJ Exec Order 26.4b1 noted on either residents. Emergency contacts made aware, and incident called in to NJDOH. Upon investigation, according to US FOIA (b)(6), [R424] who is NJ Exec O and NJ Exec Order 26.4b1 with staff anticipating NJ Exec Order 26.4b1, with NJ Exec Order 26.4b1 and able to NJ Exec Or in the day room with NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 for no apparent cause in the day room and while the aide in the day room was NJ Exec Order 26.4b1, [R426] who is NJ Exec Order 26.4b1 with Brief Interview for Mental Status (BIMS) score of NJ Exec D and able to make NJ Exec Order 26.4b1, with diagnosis of NJ Exec Order 26.4b1

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 10/17/2024

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 600	Continued From page 20	F 600		

NJ Exec Order 26.4b1 and requires staff assistance with activity of daily living (ADL)'s was NJ Exec Order 26.4b1 by [R424]'s NJ Exec Order NJ Exec Order 26.4b1 . Staff NJ Exec Order 26.4b1 . RN assessment showed NJ Exec Order 26.4b1 and NJ Exec Orde noted on both residents. [R426] was NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 consult ordered for both residents for further evaluation. NJ Exec Order 26.4b1 initiated for [R424]. [R426] on follow up indicated that she was trying to get [R424]'s NJ Exec Order 26.4b1 . Staff to ensure both residents are NJ Exec Order 26.4b1 in common shared areas and activities whenever possible. Conclusion: From investigation, interview, and review of records, [R426]'s NJ Exec Order 26.4b1 by [R424]'s NJ Exec Order 26.4b1 . Both residents have never been involved in NJ Exec Orde . Hence NJ Exec Order 2 was ruled out by the facility. NJ Exec Order 2 consult in place for both residents for further evaluation. Staff will ensure that both NJ Exec Order 26.4b1 in common shared areas and activities whenever possible and ensure the safety of all other residents maintained. Both residents are currently followed by an NJ Exec Order 26.4b1 . Social workers will continue to follow both residents to ensure their safety and well-being."

Review of R424's facility provided "NJ Exec O Assessment," dated NJ Exec Order 26.4b1 indicated NJ Exe

Review of facility provided "Employee Statement" for CNA3, dated NJ Exec Order 26.4b1 , indicated, "I was in the day room watching over the patients at about 5:00 PM then [R424] in room [room number] was brought to the day room after NJ Exec shower and

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 10/17/2024

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 600	Continued From page 21	F 600		

was seated at the table and make [redacted] as [redacted]. Then about 5:10 PM the [R426] in room [room number] wheeled over with [redacted] R424] by [redacted]. I then called the nurses for assistance and the residents [redacted] from each other."

During an interview on 10/17/24 at 9:54 AM, CNA3 stated that R424 would mainly stay in [redacted]. CNA3 stated that she was unsure of the incident.

During an interview on 10/15/24 at 4:15 PM, the RM stated that [redacted] were not considered [redacted]

During an interview on 10/16/24 at 8:50 AM, the [redacted]) confirmed that any time [redacted], that would be considered a [redacted], which is considered [redacted]

3.
a. Review of R140's [redacted] change "MDS," with an ARD of [redacted] and located under the "MDS" tab of the EMR, revealed R140 was admitted to the facility on [redacted] with diagnoses that included [redacted]
It was recorded R140 had a "BIMS" score of [redacted] out of 15, which indicated the resident was [redacted].

b. Review of R142's quarterly "MDS," with an ARD of [redacted] and located under the "MDS" tab of the EMR, revealed R142 was admitted to

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 10/17/2024

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 600	Continued From page 22	F 600		

the facility on NJ Exec Order 26.4b with diagnoses that included NJ Exec Order 26.4b1 [redacted]. It was recorded R142 had a "BIMS" score of [redacted] out of 15, which indicated the resident was NJ Exec Order 26.4b1 [redacted]

Review of R140's "Progress Notes," dated NJ Exec Order 26.4b1 and located under the "Progress Notes" tab of the EMR, revealed R140 became NJ Exec Order 26.4 [redacted] towards R142 at which time a staff member NJ Exec Order 26.4b1 both residents. Review of the facility's investigation of the incident revealed, ". . . Upon investigation, according to Staff, [R140] . . . was NJ Exec Order 26.4b1 in the unit hallway saw [R142] and started NJ Exec Order 26.4b1 unprovoked, staff saw it and NJ Exec Order 26.4b1 to ensure NJ Exec Order 26.4b1, but [R140] NJ Exec Order 26.4b1 [redacted] [R142] who was backing out from the situation. . . . NJ Exec Order 26.4b1 [redacted] . . ."

Review of R140's "Physician Orders," dated NJ Exec Order 26.4b1 and located under the "Orders" tab of the EMR, revealed NJ Exec Order 26.4b1 [redacted] three times daily was added to R140's medication regimen as an intervention for the NJ Exec Order 26.4b1 [redacted]

c. Review of R66's quarterly "MDS," with an ARD of NJ Exec Order 26.4b1 [redacted] and located under the "MDS" tab of the EMR, revealed R66 was admitted to the facility on NJ Exec Order 26.4b1 [redacted] with diagnoses that included NJ Exec Order 26.4b1 It was recorded that R66 had a "BIMS" score of NJ Exec [redacted] out of 15, which indicated the resident was NJ Exec Order 26.4b1 [redacted].

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 10/17/2024

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 600	Continued From page 23	F 600		

Review of R66's "Progress Notes," dated [redacted], revealed R66 apparently by mistake [redacted]. R140 went to the [redacted] to [redacted] R66 from [redacted]. The two residents started [redacted] about whose [redacted], and R140 [redacted] R66 on the [redacted] of [redacted]. The staff were able to intervene and [redacted]. R140 told staff using a [redacted] that [redacted] did not want R66[redacted]. Interventions for R140 included a [redacted] evaluation, ongoing [redacted], staff to ensure both residents were [redacted] from each other in common shared areas and activities, and reassigning rooms.

d. Review of R128's quarterly "MDS," with an ARD of [redacted], revealed R128 was admitted to the facility on [redacted] with diagnoses that included [redacted]. It was recorded R128 had a "BIMS" score of [redacted] out of 15, which indicated the resident was [redacted]

Review of R140's "Progress Notes," dated [redacted] and located under the "Progress Notes" tab of the EMR, revealed R140 [redacted] R128 in the [redacted]. The facility staff immediately [redacted] the two residents. R140 was [redacted], pending a [redacted] evaluation, and a medication review was made. R128 was assessed for [redacted] and moved to another unit for [redacted] wellbeing and safety with follow-up by social services. The [redacted] saw and examined R140 and started [redacted] on [redacted] an [redacted] medication, [redacted] by mouth once daily and on [redacted] an [redacted], [redacted] as needed every six hours for

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 10/17/2024

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 600	Continued From page 24 NJ Exec Order 26 for NJ Exec Order 26.4. Review of R140's "Progress Notes," dated NJ Exec Order 26.4b1 and located under the "Progress Notes" tab of the EMR, revealed R140 was sent to the hospital on NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1. R140 was treated for NJ Exec Order 26.4b1 and was readmitted to the facility on NJ Exec Order 26.4b1. It was recorded NJ Exec Order 26.4b1 was discontinued on NJ Exec Order 26.4b1, as per NJ Exec Order 26.4b1 recommendation. During an interview on 10/15/24 at 8:43 AM, R128 reported there had been no further problems with R140. During an interview on 10/15/24 at 2:46 PM, Unit Manager (UM) 3 stated that R140 was on NJ Exec Order 26.4b1 until NJ Exec Order 26.4b1 and after NJ Exec last NJ Exec Order 26.4b1 treatment, NJ Exec Order 26.4b1 had been changed to every NJ Exec Order 26.4b1. UM3 reported that R140 had been a NJ Exec Order 26.4b1 since starting the NJ Exec Order 26.4b1 and had not shown any type of NJ Exec Order 26.4b1. During an interview on 10/16/24 at 10:00 AM, the US FOIA (b)(6) stated R140 has had a NJ Exec Order 26.4b1 in NJ Exec Order and NJ Exec Order 26.4b1 since starting the NJ Exec Order 26.4b1. The US FOIA stated the NJ Exec Order 26.4b1 made adjustments to the medication that have leveled out R140's NJ Exec Order 26.4 and R140 is NJ Exec Order 2 and NJ Exec Order 26.4b1.	F 600		
F 609 SS=E	NJAC 8:39-4.1 (a)5 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		12/5/24

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 10/17/2024

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 609	Continued From page 25 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility reported incidents (FRI), and review of facility policy, the facility failed to ensure [redacted] involving four of eight residents (Resident (R) 262, R76, R426, and R424) reviewed for [redacted] out of a total sample of 45 were reported to the state agency (SA) within two hours of knowledge of the	F 609	1. Residents R262 and R76 were assessed by the [redacted] on [redacted] for any delayed [redacted] to their involvement in [redacted] No [redacted] were identified. Residents R424 and R426 no longer	

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 10/17/2024

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 609	Continued From page 26 alleged incidents. This failure had the possibility of negatively impacting all 277 residents currently residing in the facility. Findings include: Review of the facility's policy titled, "Abuse, Neglect and Exploitation," reviewed 07/2024, indicated, ". . . Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency (SA), adult protective services (APS) and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . . ." 1. Review of R262's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), indicated that R262 was admitted to the facility on [redacted] with diagnoses that included [redacted] Review of R76's "Admission Record," located under the "Profile" tab in the EMR, indicated that R76 was admitted to the facility on [redacted] with diagnoses including [redacted] Review of the facility provided "Privileged and Confidential Quality Assurance (QA) Document," dated [redacted], indicated, ". . . At 3:30 PM, [R262] [redacted]. [redacted] to [R76]'s room and [R76] said to [R262] [redacted] and [R262] got [redacted] on [sic]	F 609	reside in the facility. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all staff on the facility's policy of Abuse, Neglect and Misappropriation of Resident Property on 11/6/2024. An audit of all resident-to-resident incidents will be conducted by the Administrator and/or designee for (3) months, or until 100% compliance, to ensure that upon identification, the facility is appropriately reporting all allegations of abuse, neglect and misappropriation of resident property to the State Agency within (2) hours. 4. The Administrator/designee with review the results of the audits to determine that upon identification, the facility is appropriately reporting all allegations of abuse, neglect and misappropriation of resident property to the State Agency within (2) hours. The results of these audits will be reported to the facility's quarterly Quality Assurance and Performance Improvement committee to identify trends and concerns. The Administrator will be responsible for ensuring compliance.	

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 10/17/2024

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 609	Continued From page 27	F 609		

[R76]'s NJ Exec Or NJ Exec Order 26.4b1 noted. Noted NJ Exec Order 26.4b1 . . Immediate Action Taken: NJ Exec Order 26.4b1 both residents, NJ Exec Order 26.4b1 , NJ Exec O assessment done, physician and families notified . . ."

Review of the facility provided "Long-term Care (LTC) Reportable Event Survey [initial reporting]," dated 08/27/24, indicated, ". . . Date of Event: NJ Exec Order 26.4b1 at 3:30 PM, significant event, called in on NJ Exec Order 26.4b1 at 7:50 PM . . . Type of incident: NJ Exec Order 26.4b1 . . ."

During an interview on 10/15/24 at 4:15 PM, the US FOIA (b)(6)) stated that R76 had NJ Exec Orde 26.4b1 were reported to the state survey agency (SA) within two hours. The US FOIA stated NJ Exec Order 26.4b1 were not considered NJ Exec Order 26 The US FOIA confirmed that the initial report to the SA was not sent within two hours of learning about the incident.

2. Review of R426's "Admission Record," located under the "Profile" tab in the EMR, indicated R426 was re-admitted to the facility on NJ Exec Order 26.4b1 with a diagnosis including NJ Exec Order 26.4b1 .

Review of R424's "Admission Record," located under the "Profile" tab in the EMR, indicated that R424 was re-admitted to the facility on NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26

Review of the facility provided "Reportable Event Record/Report [initial reporting]," dated NJ Exec Order 26.4b1 , indicated, ". . . Date of Event: NJ Exec Order 26.4b1 , time of

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 10/17/2024

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 609	Continued From page 28	F 609		

event: 5:10 PM . . . Was significant event called in: yes, Date: [redacted], and time: 10:30 AM . . . Type of incident: NJ Exec Order 26.4b1 . . . On [redacted], at approximately 5:10 PM, the US FOIA (b)(6) informed the facility that our residents ([R426] and [R424]) were involved in NJ Exec Order 26.4b1 in which [R426] [redacted] [R424] on [redacted]. The incident was witnessed by US FOIA (b)(6) [redacted] [R424]. The aide was NJ Exec Order 26.4b1 because [R426] was [redacted] They were both [redacted] immediately for safety. NJ Exec Order 26.4b1 noted on both residents. Emergency contacts made aware, and incident called in to [name of state] Department of Health (NJDOH) . . . Interventions: Both residents [redacted] immediately, nurse's assessment for NJ Exec Order 26.4b1, [redacted] initiated for [R424], [redacted] consult for further evaluation for both residents, social workers follow up to ensure residents safety and well-being, staff will continue to ensure both residents are [redacted] in common shared areas and activities, and emotional support provided . . ."

During an interview on 10/17/24 at 11:45 AM, the US FOIA (b)(6)), stated that he did not remember when the incident on [redacted] was called into the SA, and he had no documentation.

During an interview on 10/17/24 at 11:45 AM, the US FOIA (b)(6) was good about calling into the SA; however, this incident occurred over the weekend, and it was not until the following Monday when the initial form was sent to the SA.

During an interview on 10/17/24 at 3:45 PM, the US FOIA (b)(6)) stated that [redacted] is

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 10/17/2024

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 609	Continued From page 29 reported to the SA within two hours, and she considered NJ Exec Order 26.4b1 incidents to be NJ Exec Order 26	F 609		
F 610 SS=E	NJAC 8:39-9.4(f) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of facility reported incidents (FRI), and review of facility policy, the facility failed to ensure NJ Exec Order 26.4b1 involving four of eight residents (Resident (R) 262, R76, R426, and R424) reviewed for NJ Exec Order 2 out of a total sample of 45 were thoroughly investigated. The failure to thoroughly investigate NJ Exec Order 26.4b1 of NJ Exec Order 2 had the potential to cause other residents to be at NJ Exec Order 26.4b1.	F 610	1. Residents R262 and R76 were assessed by the US FOIA (b)(6) on NJ Exec Order 26.4b1 for any delayed NJ Exec Order 26.4b1 due to their involvement in NJ Exec Order 26.4b1 No NJ Exec Order 26.4b1 were identified. Residents R424 and R426 no longer reside in the facility.	12/5/24

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 10/17/2024

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 610	Continued From page 30 Findings include: Review of the facility's policy titled, "Abuse, Neglect and Exploitation," reviewed 07/2024, indicated, ". . . Investigation of alleged abuse, neglect and exploitation: A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: . . . 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations . . . 6. Providing complete and thorough documentation of the investigation . . ." 1. Review of R262's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), indicated that R262 was admitted to the facility on [redacted] with diagnoses that included [redacted] Review of R262's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] and located under the "MDS" tab in the EMR, revealed R262 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated R262 was [redacted] Review of R76's "Admission Record," located under the "Profile" tab in the EMR, indicated that R76 was admitted to the facility on [redacted] with diagnoses including [redacted] Review of R76's quarterly "MDS," with an ARD of	F 610	2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all staff on the facility's policy of Abuse, Neglect and Misappropriation of Resident Property on 11/6/2024. An audit of all resident-to-resident incidents will be conducted by the Administrator and/or designee for (3) months, or until 100% compliance, to ensure allegations of resident to resident abuse are thoroughly investigated. 4. The Administrator/designee with review the results of the audits to determine that all allegations of resident to resident abuse are thoroughly being investigated. The results of these audits will be reported to the facility's quarterly Quality Assurance and Performance Improvement committee to identify trends and concerns. The Administrator will be responsible to ensure compliance.	

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 10/17/2024

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 610	Continued From page 31	F 610		

NJ Exec Order 26.4b1 and located under the "MDS" tab of the EMR, revealed R76had a "BIMS" score of [redacted] out of 15, indicated that R76 was NJ Exec Order 26.4b1.

Review of the facility provided "Concern Investigation [five-day summary]," dated NJ Exec Order 26.4b1 indicated, "On NJ Exec Order 26.4b1, at approximately 7:30 PM, the US FOIA (b)(6) informed the facility that our residents ([R76] and [R262]) were involved in NJ Exec Order 26.4b1 in which [R262] NJ Exec Order 26.4b1 [R76]'s [redacted] with NJ Exec Order 26.4b1. Both residents were NJ Exec Order 26.4b1 by staff to ensure safety. [R76] NJ Exec Order 26.4b1 on [redacted] and no [sic] [R262] with [redacted] from the incident . . . [R76] . . . reported to staff that [redacted] [R262] NJ Exec Order 26.4b1 about NJ Exec Order 26.4b1 and when NJ Exec Order 26.4b1 room, [R262] NJ Exec Order 26.4b1 and [redacted] [sic] NJ Exec Order 26.4b1 . [R76] NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 or [redacted] Staff ensured that both residents were NJ Exec Order 26.4b1 and called the US FOIA (b)(6). [R76] was educated and encouraged to always call staff to intervene with any issue she has with her peer to NJ Exec Order 26.4b1 . . [R262] on the other hand . . . [redacted] on the unit apparently went in to [R76]'s NJ Exec Order 26.4b1 and when [R76] NJ Exec Order 26.4b1 [redacted] Hence, [redacted] [meaning R262] [redacted] [R76]. [R262], who is currently on every NJ Exec Order 26.4b1 was seen by staff in NJ Exec Order 26.4b1 about 10 minutes before [R76] reported the incident . . . Conclusion: From investigation, interviews, and review of records, both [R76] and [R262] have NJ Exec Order 26.4b1 diagnosis but have not been in any [redacted]

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 10/17/2024

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 610	Continued From page 32	F 610		

NJ Exec Order 26.4b1 with each other and NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. Hence, NJ Exec Order is ruled out in this incident. [R76] was educated and encouraged to report NJ Exec Order 26.4b1 to staff so that appropriate interventions can be put in place to prevent incidents such as this and NJ Exec Order 26.4b1 . . ."

Review of the facility's investigative file of the incident revealed employee statements were obtained from five staff members, including the staff member to whom the incident was reported. There was no documentation other residents were interviewed in an effort to identify anyone else who may have been similarly affected.

During an interview on 10/15/24 at 4:15 PM, the US FOIA (b)(6) stated that this incident was a misunderstanding of someone NJ Exec Order 26.4b1 because R262 went into a different room. The US FOIA stated that since this happened in a room, there were no other residents interviewed.

2. Review of R426's "Admission Record," located under the "Profile" tab in the EMR, indicated R426 was re-admitted to the facility on NJ Exec Order 26.4b1 with diagnoses including NJ Exec Order 26.4b1

Review of R424's "Admission Record," located under the "Profile" tab in the EMR, indicated that R424 was re-admitted to the facility on NJ Exec Order 26.4b with diagnoses including NJ Exec Order 26

Review of facility provided "Concern Investigation [five-day summary]," dated NJ Exec Order 26.4b, indicated, ". . . On NJ Exec Order 26.4b1 at approximately 5:10 PM, the US FOIA (b)(6) informed the facility that our

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 10/17/2024

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 610	Continued From page 33	F 610		

residents ([R426] and [R424]) were involved in NJ Exec Order 26.4b1 in which [R426] NJ Exec Order [R424] on NJ Exec Order 26.4. The incident was witnessed by US FOIA (b)(6) NJ Exec Order 26.4b1 [R424]. The aide was NJ Exec Order 26.4b1 because [R426] was NJ Exec O They were both NJ Exec Order 26.4b1 immediately for safety. NJ Exec Order 26.4b1 noted on either residents . . . Upon investigation, according to US FOI , [R424] who is NJ Exec Order 26.4b1 . . . was NJ Exec Order 26.4b1 cause in the day room and while the aide in the day room was NJ Exec Order 26.4b1 her, [R426] . . . was NJ Exec Order 26.4 by [R424]'s NJ Exec Order NJ Exec Order 26.4b1 . Staff NJ Exec Order 26.4b1 them immediately. RN assessment showed there was NJ Exec Order 26.4b1 noted on both residents. [R426] was NJ Exec Order 26.4b1 and report to staff any issue NJ Exec Order 26.4b1 Conclusion: From investigation, interview, and review of records, [R426]'s action apparently was NJ Exec Order 26.4b1 by [R424]'s NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Both residents have never been NJ Exec Order 26.4b1 and prior NJ Exec Order 26.4b1 Hence NJ Exec Order was ruled out by the facility . . ."

Review of the facility's investigative file of the incident revealed employee statements were obtained from five staff members, including the staff member who was present at the time of the incident. There was no documentation other residents were interviewed in an effort to conduct a thorough investigation in an effort to identify anyone else who may have been similarly affected.

During an interview on 10/17/24 at 12:20 PM, the US FOIA (b)(6)) indicated he helped with NJ Exec Order investigations. He stated

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 10/17/2024

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 610	Continued From page 34 other residents are interviewed sometimes as part of an investigation if they were in the area at the time of the incident. During an interview on 10/16/24 at 3:30 PM, the [US FOIA] confirmed that there were no resident interviews conducted for this [NJ Exec Order 26.4b1]	F 610		
F 625 SS=E	NJAC 8:39-9.4(f) Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		12/5/24

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 10/17/2024

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 625	Continued From page 35 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide written information regarding the facility's bed-hold policy for six of nine residents (Resident (R) 75, R111, R127, R209, R90, and R186) reviewed for hospitalization out of a total sample of 45. The failure had the potential to cause confusion for residents planning on returning to the facility. Findings include: Review of the facility's policy titled, "Readmission To Facility," revised 07/2023, indicated, "It is the policy of this facility to protect the resident's rights to readmission by initiating a bed-hold and permitting each resident to return to the facility after they are hospitalized or placed on therapeutic leave, regardless of payment source . . . Procedure: 1. The facility will initiate a bed-hold and permit residents to return to the facility and resume residence after they are hospitalized or placed on therapeutic leave . . . 4. Residents who seek to return to the facility within the bed-hold period in the state plan are allowed to return to their previous room, if available . . ." 1. Review of R75's "Progress Notes," dated NJ Exec Order 26.4b1 and located under the "Progress Notes" tab of the electronic medical record (EMR), revealed [redacted] had been transferred to the hospital for a NJ Exec Order 26.4b1. It was recorded R75 returned to the facility on NJ Exec Order 26.4b1 Review of R75's "Progress Notes" and "Misc (Miscellaneous)" tabs of the EMR revealed no	F 625	1. Residents R75, R111, R127, R209, R90 and R186 have all returned to the facility without NJ Exec Order 26.4b1. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Administrator re-educated the Social Services department on the facility's bed-hold policy, specifically the requirement that all residents and/or resident representatives be provided with a written bed-hold notice upon a therapeutic leave or hospital discharge on 11/8/2024. An audit of all hospital discharges and therapeutic leaves will be conducted by the Social Services Director and/or designee weekly for (8) weeks, or until 100% compliance, to ensure that all residents and/or resident representatives were provided with a written bed-hold notice. 4. The Social Services Director will review the audit results to determine if all residents and/or resident representatives were provided with a written bed-hold notice upon a therapeutic leave or hospital discharge. The results of these audits will be	

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 10/17/2024

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 625	Continued From page 36 documentation R75 or [redacted] representative were provided with written notice of the state or facility's bed-hold policies when transferred to the hospital. 2. Review of R111's "Face Sheet," located under the "Profile" tab of the electronic medical record (EMR) indicated R111 was re-admitted to the facility on [redacted] with diagnoses including [redacted]. Review of R111's "Progress Note," dated [redacted] and located under the "Notes" tab of the EMR, indicated, ". . . Around 4:00 PM, [R111] complained of [redacted] [R111] [redacted] . . [R111] wants to go to emergency room (ER) for evaluation . . . Around 4:40 PM [R111] was transferred to ER [emergency room] . . ." Review of R111's "Notice of Emergency Transfer," dated [redacted] and provided by the facility, indicated, ". . . The reason for the transfer was: [redacted] . . ." Review of the EMR "Misc (Miscellaneous)" tab indicated no evidence of a bed hold notice was provided to the resident when transferred to the emergency room. 3. Review of R127's "Face Sheet," located under the "Profile" tab of the EMR, indicated R127 was re-admitted to the facility on [redacted] with diagnoses that included [redacted]	F 625	reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Director of Social Work will be responsible for ensuring compliance.	

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 10/17/2024

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 625	Continued From page 37 Review of R127's "Progress Notes," dated NJ Exec Order 26.4b1 and located under the "Notes" tab of the EMR, indicated, ". . . [R127] noted NJ Exec O NJ Exec Order 2 in NJ Exec Order 26.4b1 . . . orders to transfer to hospital for evaluation . . ." Review of R127's "Notice Emergency Transfer," dated NJ Exec Order 26.4b1 and provided by the facility, indicated, ". . . The reason for the transfer was: Evaluation for NJ Exec Order 26.4b1) . . ." Review of the EMR "Misc" tab indicated no evidence of a bed hold notice was provided to the resident when transferred to the hospital. During an interview on 10/16/24 at 2:00 PM, the US FOIA (b)(6)) confirmed that bed hold notices were not provided to residents and/or their responsible parties. 4. Review of R209's significant change "MDS," with an ARD of NJ Exec Order 26.4b1 and located under the "MDS" tab of the EMR, revealed R209 was readmitted to the facility on NJ Exec Order 26.4b1 ; had diagnoses of NJ Exec Order 26.4b1 and had a "BIMS" score of NJ Exe out of 15, which indicated R209 was NJ Exec Order 26.4b1 Review of R209's "Progress Notes," dated NJ Exec Order 26.4b1 at 2:00 PM and located under the "Progress Notes" tab of the EMR, revealed R209 was transferred to the hospital for NJ Exec Order 26.4b1 The "Progress Notes," dated NJ Exec Order 26.4b1 at 7:13 PM and located under the "Progress Notes" tab of the EMR, revealed R209 returned to the facility. Review of R209's "Misc" and "Progress Notes" tabs of the EMR revealed no documentation	F 625		

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 10/17/2024

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 625	Continued From page 38	F 625		

R209 and/or [NJ Exec] responsible party were provided a bed-hold notice at the time of transfer to the hospital.

During an interview on 10/17/24 at 10:30 AM, R209 stated [NJ Exec] remembered going to the hospital, but [NJ Exec] did not remember receiving any bed-hold paperwork.

5. Review of R90's "Admission Record," located under the "Profile" tab of the EMR, revealed R90 was readmitted to the facility on [NJ Exec Order 26.4b1] with diagnoses that included NJ Exec Order 26.4b1 [redacted]

Review of R90's "Progress Notes," dated [NJ Exec Order 26.4b] at 1:07 PM and located under the "Progress Notes" tab of the EMR, revealed R90 was transferred to the hospital and there admitted with diagnoses that included NJ Exec Order 26.4b1 [redacted]. The "Progress Notes," dated [NJ Exec Order 26.4b] at 10:33 PM and located under the "Progress Notes" tab of the EMR, revealed the resident returned to the facility.

Review of R90's "Misc" and "Progress Notes" tabs of the EMR revealed no documentation R90 and/or [NJ Exec] responsible party were provided a bed-hold notice at the time of transfer to the hospital.

During an interview on 10/17/24 at 10:50 AM, R90 stated [NJ Exec] remembered going to the hospital, but [NJ Exec] did not remember getting any bed hold paperwork or having the policy explained.

6. Review of R186's quarterly "MDS," with an ARD of [NJ Exec Order 26.4b] and located under the "MDS"

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 10/17/2024

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 625	Continued From page 39 tab of the EMR, revealed R186 was readmitted to the facility on [redacted] with diagnoses that included [redacted]. Review of R186's "Progress Notes," tab revealed that on [redacted], R186 was transferred to the hospital and admitted there for [redacted] It was recorded that the resident returned to the facility on [redacted] Review of R186's "Misc" and "Progress Notes" tabs of the EMR revealed no documentation R186 and/or [redacted] responsible party were provided a bed-hold notice at the time of transfer to the hospital. During an interview on 10/14/24 at 1:30 PM, R186 stated [redacted] remembered going to the hospital, but [redacted] did not remember getting any bed hold paperwork or having the policy explained. During an interview on 10/17/24 at 1:35 PM, the facility's [redacted] stated that the facility did not have a bed hold policy. NJAC 8:39-5.1(a) NJAC 8:39-5.2(a)	F 625		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		12/5/24

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 10/17/2024

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 686	Continued From page 40 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure interventions to aid in the [redacted] were implemented as per the plan of care for one of five residents (Resident (R) 157) reviewed for [redacted] out of a total sample of 45. This failure had the potential to contribute to [redacted] the resident's [redacted] Findings include: Review of the facility's policy titled, "Pressure Injury Prevention Policy," dated 07/2023, revealed, ". . . Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used . . . " Review of R157's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R157 was admitted to the facility on [redacted] with diagnoses that included [redacted]. Review of R157's "Care Plan," dated [redacted] and located under the "Care Plan" tab of the EMR, revealed R157 had [redacted] Interventions included treatments as ordered, referral to the [redacted] physician and [redacted] and [redacted].	F 686	1. Resident R157 was assessed by the [redacted] on [redacted] to determine the outcome of not having [redacted] in place. No [redacted] were identified. LPN 8 was re-educated by the Staff Educator on 11/5/2024 to ensure that interventions to aid in the healing of pressure ulcers were implemented per the resident's plan of care. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all nursing staff on the facility's Pressure Injury Prevention policy on 11/5/2024. An audit of (10) residents requiring interventions to aid in the healing of pressure ulcers will be conducted by the Director of Nursing and/or designee weekly for (4) weeks, or until there is 100% compliance, to ensure that interventions are in place. The Director of Nursing/designee will review the results of these audits to determine if interventions to aid in the	

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 10/17/2024

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 686	Continued From page 41 Review of R157's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b and located under the "MDS" tab of the EMR, revealed R157's "'Brief Interview for Mental Status (BIMS)" score was a NJ Exec out of 15, which showed she was NJ Exec Order 26.4b1. It was recorded R157 had NJ Exec Order 26.4b1 and treatments included NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 program, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to manage NJ Exec O problems, NJ Exec Order 26.4b1, and application of NJ Exec Order 26.4b1 to NJ Exec O with or without NJ Exec Order 26.4b1. During an observation on 10/15/24 at 10:15 AM, R157 was observed lying in bed with the NJ Exec Order 26.4b and NJ Exec Order 26.4b1 and NJ Ex Order 26.4(b)(1) in the bed. R157 stated NJ Exec Order 26.4b NJ Exec O did not have NJ Exec Order 26.4b1. There was NJ Exec Order NJ Exec Order 26.4b around both of NJ Exec Order 26.4b1, and both of NJ Exec Order 26.4b1 were NJ Exec Order 26.4b on the NJ Exec Order 26.4b1 The NJ Exec Orde were not NJ Exec Order 26.4b to NJ Exec Order 26.4b During an observation on 10/15/24 at 11:28 AM, R157 did not have NJ Exec Order 26.4b1 on. NJ Exec O NJ Exec Order 26.4b1 and were not NJ Exec Order 26.4b1. During an observation on 10/15/24 at 1:36 PM, Licensed Practical Nurse (LPN) 8 was observed providing a NJ Exec Order 26.4b change to R157's NJ Exec Order 26.4b R157 did not have NJ Exec Order 26.4b1 on. LPN8 stated R157 should have NJ Exec Order 26.4b1 on. LPN8 searched the resident's room and found the NJ Exec Order 26.4b1 NJ Exec Orde in the resident's closet.	F 686	healing of pressure ulcers were implemented per the resident's plan of care. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Director of Nursing will be responsible for ensuring compliance.	

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 10/17/2024

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 686	Continued From page 42 During an interview on 10/17/24 at 12:10 PM, the Assistant Director of Nursing (ADON) 1 and Minimum Data Set Coordinator (MDSC) 1 confirmed R157 should have NJ Exec Order 26.4b1 on at all times.	F 686		
F 697 SS=G	NJAC 8:39-27.1(e) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one (1) of one (1) residents (Resident #157) reviewed for NJ Exec O management received NJ Exec O management related to NJ Exec Order 26.4b1 . Resident #157 exhibited signs and symptoms of NJ Exec O during their dressing change and staff failed to stop the treatment. The resident was not pre-medicated for NJ Exec O which caused Resident #157 to suffer NJ Exec Order 26.4b1. Findings Include: Review of Resident #157's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed Resident #157 was admitted to the facility with diagnoses which included but not limited to NJ Exec Order 26.4b1	F 697	1. Resident R157 was assessed by the US FOIA (b)(6) on NJ Exec Order 26.4b1 to determine the outcome of not receiving NJ Exec O management prior to the treatment on NJ Exec Order 26.4b1. The resident NJ Exec Order 26.4b1 at the time of treatment. No NJ Exec Order 26.4b1 was identified. A NJ Exec Ord Assessment was conducted for Resident R157 by the US FOIA (b)(6) on NJ Exec Order 26.4b1 and the resident denied experiencing any type of NJ Exec Ord LPN 8 was re-educated by the Staff Educator on 11/5/2024 on the facility's Pain Management policy to ensure that pain management is provided to residents who verbalize or demonstrate non-verbal indicators of pain.	12/5/24

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 10/17/2024

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 697	Continued From page 43 Review of Resident #157's "Care Plan," located under the "Care Plan" tab of the EMR and dated [redacted], revealed the resident had potential for [redacted] related to their [redacted] process. Interventions included administering [redacted] medications as ordered, anticipating the need for [redacted], responding immediately to any complaint of [redacted] and notifying the physician if interventions were unsuccessful or if the resident's current complaint was a [redacted] Review of Resident #157's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted], and located under the "MDS" tab of the EMR, revealed Resident #157 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated the resident was [redacted]. Further review of the MDS revealed that Resident # 157 had [redacted] was not on a scheduled [redacted] medication regimen, did not receive as needed (PRN) [redacted] medication, and did not report [redacted] Review of Resident #157's "Medication Administration Record (MAR)," dated [redacted] and located under the "Orders" tab of the EMR, revealed Resident #157 had a physician order for [redacted] two tablets, two times a day at 9:00 AM and 5:00 PM and [redacted] two tablets every six hours as needed for [redacted] There was no documented evidence that Resident #157 received either the scheduled or as needed [redacted] from [redacted] through [redacted] On 10/15/24 at 10:15 AM, the surveyor observed Resident #157 was lying in bed and was [redacted] The resident stated they had [redacted] in	F 697	A review of R157's electronic Medication Administration Record (eMAR) for the period of [redacted] indicated that the resident received all scheduled doses of [redacted] for [redacted] twice a day (9:00 AM and 5:00 PM). A review of R157's electronic Medication Administration Record (eMAR) for the period of [redacted] indicated that the resident received a [redacted] every shift and the resident [redacted]. Resident R157's Quarterly Minimum Data Set (MDS) for Assessment Reference Date [redacted] was modified by the MDS Coordinator on [redacted] to indicate that the resident did in fact receive a [redacted] regimen during the look-back period. R157 is [redacted] with the ability to [redacted]. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all licensed nurses on the facility's Pain Management policy on 11/5/2024. An audit of (10) residents requiring pain management will be conducted by the	

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 10/17/2024

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 697	Continued From page 44 both of their NJ Exec Order. The surveyor observed that Resident #157 had NJ Exec Order 26.4b1 around their NJ Exec Orde and their NJ Exec Orde were resting on the NJ Exec Order 26.4b1 with no NJ Exec Order 26.4b1 in use. On 10/15/24 at 1:36 PM, the surveyor observed the Licensed Practical Nurse (LPN #8) providing a NJ Exec Order 26.4b1 to Resident #157's NJ Exec Order 26. Resident #157 did not have NJ Exec Order 26.4b1 on prior to start of the NJ Exec Order 26.4b1. LPN #8 began to remove the NJ Exec Order NJ Exec Order 26.4b the NJ Exec Order 26.4b1, and the NJ Exec Order was NJ Exec Orde to the NJ Exec Orde Resident #157 was NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and grabbed the NJ Exec Order 26.4b1 until the resident's NJ Exec Order 26.4b1 were NJ Exec Order LPN #8 asked Resident #157 if they wanted her to stop but continued with the NJ Exec Order 26.4b1. Resident #157 NJ Exec Order 26 Resident # 157 continued to NJ Exec Order 26.4b1 NJ Exec Order and NJ Exec Order 26.4b1 during the entire NJ Exec Order 26.4b1. On 10/15/24 at 2:15 PM, the surveyor interviewed the LPN #8 who confirmed Resident #157 had NJ Exec O during the NJ Exec Order 26.4b1. LPN #8 confirmed she had not given any NJ Exec Order 26.4b1 to Resident #157 prior to the NJ Exec Order 26.4b1. She stated she did not know if any medication was available for Resident #157 prior to the NJ Exec Order 26.4b1. On 10/17/24 at 8:21 AM, the surveyor interviewed the Certified Nursing Assistants (CNA #19) and (CNA #21) who stated Resident #157 only NJ Exec Orde out or showed NJ Exec O was when the resident's NJ Exec O were NJ Exec Order 26. On 10/17/24 at 12:10 PM, the surveyor interviewed the Assistant Director of Nursing	F 697	Director of Nursing and/or designee weekly for (8) weeks to ensure such services are being received routinely and as needed. 4. The Director of Nursing/designee will review the audit results to determine if licensed staff are ensuring that pain management is being provided to residents who verbalize or demonstrate non-verbal indicators of pain. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Director of Nursing/designee will be responsible for ensuring compliance.	

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 10/17/2024

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 697	Continued From page 45 (ADON #1) and Minimum Data Set Coordinator (MDSC #1) who stated they were not aware of Resident #157's [NJ Exec O] with [NJ Exec Order 26.4b1] and movement of their [NJ Exec O]. They confirmed that Resident # 157 should have been medicated for [NJ Exec O] prior to the [NJ Exec Order 26.4b1]. The survey team met with the administrative staff requesting policies on [NJ Exec O] management and [NJ Exec Order 26.4b1]. There was no additional information provided.	F 697		
F 761 SS=D	NJAC 8:39-27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		12/5/24

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 10/17/2024

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 761	Continued From page 46 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to ensure that two residents (Resident (R) 110 and R76) from a sample of 45 residents had a way of making sure that medications were secured. This failure has the potential to expose residents to hazards of unsecure medications. Findings include: Review of the facility's policy titled, "Medication Administration Policy," dated 03/2023, indicated, "It is the policy of this facility to ensure that facility staff follows the guidelines for a safe, timely and accurate administration of resident medications. Procedure . . . The licensed nurse is responsible to . . . Assures medications are not left unattended. Keeps medications secured in a locked area or in visible control at all times . . ." 1. Review of R110's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), indicated that R110 was re-admitted to the facility on NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1. Review of R110's "Order Summary Report," dated NJ Exec Order 26.4b1 and located under the "Orders" tab of the EMR, indicated, NJ Exec Order 26.4b1 [redacted]	F 761	1.Residents R110 and R76 were assessed by the US FOIA (b)(6) [redacted] on NJ Exec Order 26.4b1 to determine the outcome of having the medications unattended. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was identified. On 10/18/2024 the US FOIA (b)(6) [redacted] notified resident R76's attending physician that the resident did not receive their medication. The Pharmacy Consultant educated LPN 2 and Unit Manager 1 on medication administration with a focus on securing resident medications at all times on 10/17/2024. The Assistant Director of Nursing educated Unit Manager 1 on medication administration with focus on securing resident medications at all times on 10/18/2024. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating all licensed staff on the facility's Medication Administration policy on 11/5/2024.	

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 10/17/2024

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 761	Continued From page 47 NJ Exec Order 26.4b1 [redacted] . . ." During a medication pass observation on 10/14/24 at 12:35 PM, Unit Manager (UM) 1 retrieved the NJ Exec Order 26.4b1 out of the medication drawer and placed them on top of the medication cart. UM1 shut the medication drawer, locked the medication cart, went into R110's room, and washed his hands. The UM1 came back two minutes later, obtained the NJ Exec Order 26.4b1, went back into R110's room, and administered the NJ Exec Order 26.4b1 to R110. 2. Review of R76's "Admission Record," located under the "Profile" tab in the EMR, indicated that R76 was admitted to the facility on NJ Exec Order 26.4b1 with diagnoses that included NJ Exec Order 26.4b1 [redacted]. During an observation on 10/14/24 at 12:45 PM with R76, there was a clear cup of at least four different medications on the resident's overbed table. The medication cup was filled medication, including one small round white pill, one oblong red pill, one medium white pill, and one small tan pill. The surveyor was unable to identify the other medications. R76 told the surveyor NJ Exec Order 26.4b1 [redacted] During an interview on 10/14/24 at 12:50 PM, Licensed Practical Nurse (LPN) 2 confirmed that she had given R76 NJ Exec medication this morning. LPN2 stated the resident NJ Exec Order 26.4b1 the medications at that time and twice NJ Exec Order 26 to give the medications back to NJ Exec LPN2 stated that she just could not take the medication cup from R76, and that was the reason R76 still had the	F 761	An audit of (10) nurses' medication administration will be conducted by the Director of Nursing and/or designee weekly for (4) weeks to ensure resident medications are being secured at all times. 4. The Director of Nursing/designee will review the audit results to determine if licensed staff are securing resident medications at all times The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Director of Nursing will be responsible for ensuring compliance.	

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 10/17/2024

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 761	Continued From page 48 medications. LPN2 was unable to tell the surveyor what medications were in the medication cup. During an interview on 10/17/24 at 9:18 AM, the US FOIA (b)(6) confirmed that no medications should be left either with a resident and/or on top of the medication cart and out of the nurse's line of sight. The US FOIA (b) stated that if the resident did not take their medication when the nurse was present, then the nurse was to remove the medication from the resident.	F 761		
F 804 SS=E	NJAC 8:39-29.4(h) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and test tray sample, the facility failed to provide food that was palatable, flavorful and at proper temperature for nine of nine residents (Resident (R) 111, R162, R117, R23, R44, R140, R152, R177, and R200) reviewed for food palatability. This failure had the potential for residents who disliked a meal to experience	F 804	1. The Registered Dietician conducted a review of the affected residents' weights on 11/1/2024. There was NJ Exec Order 26.4b1 or any other indication that the residents experienced any NJ Exec Order 26.4b1 problems. 2. All residents have the potential to be affected by the same alleged deficient	12/5/24

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 10/17/2024

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 804	Continued From page 49 nutritional problems or dissatisfaction with their meals. Findings include: Review of the facility's policy and procedure for "Holding Hot Food Prior to Service," last revised 04/20/2022, revealed, ". . . It is the policy of this facility to hold hot food at acceptable temperature range prior to service . . . Upon removal from the oven or stove, cooked meats are to be kept at an internal temperature of 140 degrees or higher in a steamtable, or suitable device . . ." 1. Review of R111's "Admission Record," located under the "Profile" tab in the EMR, indicated that R111 was re-admitted to the facility on [redacted] with a diagnosis of [redacted] Review of R111's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of [redacted] and located under the tab "MDS" in the EMR, indicated that R111's "Brief Interview for Mental Status (BIMS)" score was [redacted] out of 15, which indicated that R111 was [redacted]. Review of R111's "Order Summary Report," located under the "Orders" tab of the EMR and dated [redacted] indicated, [redacted]." During an interview on 10/14/24 at 12:16 PM, R111 stated that sometimes the food was cold. R11 stated it could happen on all meals. 2. Review of R162's "Admission Record," located under the "Profile" tab of the EMR, indicated that R162 was admitted to the facility on [redacted] with	F 804	practice. 3. All Chefs will be re-educated on proper food preparation, seasoning and required temperature standards. Dietary staff will be re-educated to conduct temperature checks before and during food service to confirm that items being sent to the residents meet the required temperature standards. A Resident Food Preference Committee will be established and will meet monthly to discuss food-related concerns, preferences, and suggestions. 4. A bi-weekly audit will be conducted by the Food Service Director and/or designee for (8) weeks to ensure adherence to corrective actions, especially food temperature controls. A monthly review of the Resident Food Preference Committee minutes will be conducted by the Administrator and/or designee to determine if improvements to food related concerns and preferences are being made. The results of these audits will be reviewed at the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Food Service Director will be responsible for ensuring compliance.	

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 10/17/2024

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 804	Continued From page 50 diagnoses that included NJ Exec Order 26.4b1 [redacted]. Review of R162's quarterly "MDS," located under the tab "MDS" in the EMR and with an ARD' of [redacted], revealed R162 had a "BIMS" score of [redacted] out of 15, which indicated that R162 was NJ Exec Order 26.4b1. Review of "Order Summary Report," dated [redacted] and located under the "Orders" tab of the EMR, indicated, NJ Exec Order 26.4b1 [redacted] During an interview on 10/14/24 at 12:23 PM, R162 stated that the food was overcooked and had no taste. 3. Review of R117's "Admission Record," located under the "Profile" tab in the EMR, indicated R117 was admitted to the facility on [redacted] with a diagnosis of NJ Exec Order 26.4b1 [redacted]). Review of R117's annual "MDS," located under the "MDS" tab in the EMR and with an ARD of [redacted] revealed R117 had a "BIMS" score of [redacted] out of 15, which indicated R117 was NJ Exec Order 26.4b1. Review of R117's "Order Summary Report," dated [redacted] and located under the "Orders" tab in the EMR, indicated, 'NJ Exec Order 26.4b1 [redacted] During an interview on 10/14/24 at 11:53 AM, R117 stated that the food is sometimes cold and sometimes bland. R117 stated that sometimes the food is not cooked enough, but did not give	F 804		

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 10/17/2024

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 804	Continued From page 51	F 804		

an example. R117 stated that [NJ Exec Order 26.4b1] was the resident [NJ Exec Order 26.4b1], and food concerns had been brought up during the meeting, and the dietary manager had come to the meetings as well.

4. Review of "Resident Council Minutes," dated October 2023 through October 2024 and provided by the [US FOIA (b)(6)] revealed the following documentation regarding food quality:

October 2023 - hot foods are "lukewarm."
November 2023 - ". . . understand food cannot have a lot of spices but needs more flavor . . ."
February 2024 - ". . . Need better quality food . . ." "Better quality meals, more varieties . . ." March 2024 - ". . . Variety of foods. Requesting more hot meals . . ." ". . . Food quality needs to be improved. Better quality meals. Not tasty . . ."
April 2024 - ". . . Sometimes cold . . . " and ". . . Food needs to be tasty - better variety . . ."
May 2024 - ". . . Better quality foods . . ."
June 2024 - ". . . Food quality is not satisfying . . ."
July 2024 - ". . . Needs better quality meals and menus . . ."

Interview with Resident Council President and six Residents (R23, R44, R117, R140, R152, R177, and R200) during the Resident Council interview on 10/15/2024 at 2:00 PM revealed that there were frequent complaints from residents about the food being cold and tasteless. The residents stated that it was a continuing problem, and the facility had not addressed the problem.

Interview with the [US FOIA (b)(6)] on 10/16/24 at 11:15 AM revealed that the [US FOIA (b)] did not attend any of the Resident Council meetings. The [US FOIA (b)] was unaware of any concerns about the hot food temperatures being cold and the food

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 10/17/2024

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 804	Continued From page 52 quality being tasteless. During the noon meal preparation on 10/16/24 at 11:30 AM., food for the meal was removed from the oven, temperatures were obtained, and the food was placed on the steam table. The food temperatures when removed from the oven were: Seasoned chicken thighs- 160 degrees Fahrenheit (F) Italian green beans - 200 degrees F. Carrots - 170 degrees F. The meal trays were prepared and then loaded onto covered carts at 11:35 AM to begin delivery to resident rooms. No temperatures were observed to be taken during this time. During an interview at 11:40 AM, the [redacted] was asked for the food temperature logbook for the steam table. The [redacted] stated that they did not have one. While still in the kitchen, samples were taken for the test tray, which was the final tray from lunch at 1:00 PM. The [redacted] and the [redacted] were present. The [redacted] tested the food temperature using the facility's food thermometer. The temperature of the seasoned chicken thighs was 117 degrees F. The temperature of the Italian green beans was 114 degrees F. The temperature of the carrots was 112 degrees F. The tray was then covered and placed in the food cart. The cart was taken to the last unit and the last room to be served. At 1:15 PM, the food temperatures were taken again by the [redacted] The temperature of the seasoned chicken thighs was 113 degrees F. The temperature of the Italian green beans was 112	F 804		

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 10/17/2024

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 804	Continued From page 53 degrees F. The temperature of the carrots was 110 degrees F. At 1:15 PM, the surveyor, US FOIA (b)(6) each tasted the seasoned chicken thigh. All agreed that it was cold and was not flavorful. The surveyor, US FOIA (b)(6) each tasted the Italian green beans and carrots. All agreed that they were cold and not flavorful. When questioned about the food temperature and quality, there was no response from the US FOIA (b)(6). During an interview on 10/17/24 at 10:30 AM, the US FOIA (b)(6)), who stated there were Morning Meetings/QA meetings that were attended by department heads, including the US FOIA (b)(6) stated that they were aware of the food complaints. The US FOIA stated several conversations had occurred with the US FOIA (b) about the food quality during the morning meetings. The US FOIA supplied three examples of recent Morning Meeting/QA notes where food issues were discussed. Review of Morning Meeting/QA notes dated 09/12/24, 09/25/24, and 10/03/24, revealed, ". . . Units one and two complain about food temperatures . . .," ". . . Issues with food temps on Units two and eight . . . US FOIA (b) to check temps . . .," and ". . . Residents complain about food temps being low . . ." During an interview on 10/17/24 at 11:30 AM, the US FOIA (b) stated that starting today, they would be taking periodic temperatures on the steam table, while they are loading the food trays.	F 804		

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 10/17/2024

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 804	Continued From page 54 NJAC 8:39-17.4(a) (2)(d)	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to maintain proper food holding temperatures. This had the potential to affect 273 of 273 residents who ate food from the kitchen. This failure had the potential to cause food borne illness in the facility. Findings include: Review of the facility's policy and procedure for "Holding Hot Food Prior to Service," last revised 04/20/2022, revealed, ". . . It is the policy of this	F 812	1. A review of the Infection Preventionist's resident line list was conducted on 11/1/2024 and no record of any resident sustaining a food borne illness or symptoms related to a food borne illness was noted. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. All Chefs will be re-educated on proper food preparation and temperature	12/5/24

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 10/17/2024

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 812	Continued From page 55 facility to hold hot food at acceptable temperature range prior to service . . . Upon removal from the oven or stove, cooked meats are to be kept at an internal temperature of 140 degrees or higher in a steamtable, or suitable device . . ." During the noon meal preparation on 10/16/24 at 11:30 AM., food for the meal was removed from the oven, temperatures were obtained, and the food was placed on the steam table. The food temperatures when removed from the oven were: Seasoned chicken thighs- 160 degrees Fahrenheit (F). Italian green beans - 200 degrees F. Carrots - 170 degrees F. The meal trays were prepared and then loaded onto covered carts at 11:35 AM to begin delivery to resident rooms. No temperatures were observed to be taken during this time. During an interview at 11:40 AM, the [US FOIA (b)] was asked for the food temperature logbook for the steam table. The [US FOIA (b)] stated that they did not have one. While still in the kitchen, samples were taken for the test tray, which was the final tray from lunch at 1:00 PM. The[US FOIA (b)(6)] were present. The [US FOIA (b)] tested the food holding temperatures using the facility's food thermometer. The temperature of the seasoned chicken thighs was 117 degrees F. The temperature of the Italian green beans was 114 degrees F. The temperature of the carrots was 112 degrees F. The tray was then covered and placed in the food cart.	F 812	standards. Dietary staff will be re-educated to conduct temperature checks before and during food service to confirm that items being sent to the residents meet the required temperature standards. 4. A bi-weekly audit will be conducted by the Food Service Director and/or designee for (8) weeks to ensure adherence to corrective actions, especially food temperature controls. The results of these audits will be reviewed at the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Food Service Director will be responsible for ensuring compliance.	

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 10/17/2024

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 812	Continued From page 56 During an interview on 10/17/24 at 10:30 AM, the US FOIA (b)(6)), who stated there were Morning Meetings/QA meetings that were attended by department heads, including the US FOIA (b)(6) stated that they were aware there were food complaints. The US FOIA stated several conversations had occurred with the US FOIA (b) about the food quality during the morning meetings. The US FOIA supplied three examples of recent Morning Meeting/QA notes where food issues were discussed. Review of Morning Meeting/QA notes dated 09/12/24, 09/25/24, and 10/03/24, revealed, ". . . Units one and two complain about food temperatures . . .," ". . . Issues with food temps on Units two and eight . . . US FOIA (b) to check temps . . .," and ". . . Residents complain about food temps being low . . ." During an interview on 10/17/24 at 11:30 AM, the US FOIA (b) stated that starting today, they would be taking periodic temperatures on the steam table, while they are loading the food trays.	F 812		
F 847 SS=F	NJAC 8:39-17.2(g) Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any	F 847		12/5/24

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 10/17/2024

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 847	Continued From page 57 resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State	F 847		

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 10/17/2024

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 847	Continued From page 58 Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to inform three of three residents and/or their responsible parties (Resident (R) 380, R112, and R265) reviewed for arbitration agreements out of a total sample of 45 of their right to rescind the arbitration agreement within 30 calendar days and their right to not be required to enter into a binding arbitration agreement as a condition of admission. Findings include: Review of the facility's undated "Admission Agreement" revealed in section 9. Miscellaneous Category G, "Disputes, Any controversy, dispute or disagreement arising out of or in connection with this Agreement, the breach thereof, or the subject matter thereof including Facility's obligation thereof shall be settled by binding arbitration, which shall be conducted in Jersey City, New Jersey in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and which to the extent of the subject matter of the arbitration shall be binding not only on all the parties to this Agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliates joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof." The Admission Agreement and Arbitration Agreement did not have language informing the resident or responsible party of their right to rescind the arbitration agreement with 30	F 847	1. An letter from Administration was given to Residents R380, R112 and R265 indicating that the facility no longer offers a Binding Arbitration Agreement and previously signed agreements are now null and void. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Administrator updated the facility's Admissions Agreement to reflect that the facility does not offer a Binding Arbitration Agreement on 10/30/2024. A letter from Administration was sent to all residents and/or resident representatives indicating that the facility no longer offers a Binding Arbitration Agreement and previously signed agreements are now null and void. An audit of all new admissions will be conducted by the Administrator and/or designee monthly for (1) month to ensure that the updated Admissions Agreement is being utilized. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns.	

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 10/17/2024

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 847	Continued From page 59 calendar days. The agreement failed to contain language which clearly informed the residents or their representative they were not required to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at the facility. Review of the facility's undated binding Arbitration Agreements Policy revealed, "This facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission to or as a requirement to continue to receive care at, this facility." During an interview on 10/15/24 at 3:20 PM with the US FOIA (b)(6) stated there was a clause in the admission packet regarding arbitration and the US FOIA (b)(6) went over that with the families. During an interview on 10/16/24 at 3:53 PM, the US FOIA (b)(6) stated the facility's Arbitration Agreement was in the Admission Agreement. She stated it was explained to the residents that if they had concerns or needed to contest something, they can find resolutions before involving the court systems, and the facility has that right as well. The US FOIA (b)(6) stated information related to patients' rights, consent to treatment, and financial information was all in the admission packet. The US FOIA (b)(6) stated they tried to get residents to sign within 24 to 48 hours of admission. She stated some resisted at first, but if the Admission Agreement was not signed, then the consent to treat was not signed either. The US FOIA (b)(6) was asked if signing the Admission Agreement was also signing the	F 847	The Administrator will be responsible for ensuring compliance.	

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 10/17/2024

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 847	Continued From page 60 Arbitration Agreement. She stated, "Yes." Review of R112's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 and located under the "MDS" tab of the EMR, revealed R112 scored NJ Exec out of 15 on the "Brief Interview for Mental Status (BIMS)," which indicated the resident was NJ Exec Order 26.4b1 . During an interview on 10/17/24 at 12:03 PM, R112 stated NJ Exec had signed NJ Exec Admission Agreement. NJ Exec stated the US FOIA (b)(6) had explained things, NJ Exec had NJ Exec Order 26.4b1 what they were saying, and if NJ Exec did not, they would explain them to NJ Exec R112 was asked if NJ Exec remembered signing an Arbitration Agreement. NJ Exec stated NJ Exec did not remember that.	F 847		
F 848 SS=F	NJAC 8:39-13.1(a) Binding Arbitration Agreements CFR(s): 483.70(m), 483.70(m)(2)(iii)(iv)(6) §483.70(m) Binding Arbitration Agreements. If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties.	F 848		12/5/24

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 10/17/2024

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 848	Continued From page 61 §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure their arbitration agreement informed three of three residents and/or their responsible parties (Resident (R) 380, R112, and R265) reviewed for arbitration agreements out of a total sample of 45 of their right to the selection of a neutral arbitrator agreed upon by both parties. The agreement also failed to inform the residents and/or their representatives of their right to select a venue for arbitration that was convenient to both parties. Findings include: Review of a copy of the facility's undated "Admission Agreement" revealed in section 9. Miscellaneous Category G, "Disputes, Any controversy, dispute or disagreement arising out of or in connection with this Agreement, the breach thereof, or the subject matter thereof including Facility's obligation thereof shall be settled by binding arbitration, which shall be conducted in Jersey City, New Jersey in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and which to the extent of the subject matter of the arbitration shall be binding not only on all the parties to this Agreement, but on any other entity controlled by, in control of or under common	F 848	1. An letter from Administration was given to Residents R380, R112 and R265 indicating that the facility no longer offers a Binding Arbitration Agreement and previously signed agreements are now null and void. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Administrator updated the facility's Admissions Agreement to reflect that the facility does not offer a Binding Arbitration Agreement on 10/30/2024. A letter from Administration was sent to all residents and/or resident representatives indicating that the facility no longer offers a Binding Arbitration Agreement and previously signed agreements are now null and void. An audit of all new admissions will be conducted by the Administrator and/or designee monthly for (1) month to ensure that the updated Admissions Agreement is being utilized. The results of these audits will be	

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 10/17/2024

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 848	Continued From page 62 control with then party to the extent that such affiliates joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof." Review of the facility's undated binding Arbitration Agreements Policy revealed, "This facility asks all residents to enter into an agreement for binding arbitration. We do not require binding arbitration as a condition of admission to or as a requirement to continue to receive care at this facility." During an interview on 10/16/24 at 3:53 PM, the US FOIA (b)(6) revealed, "The Arbitration Agreement is in the admission packet." The US FOIA (b)(6) stated that by signing the admission packet, the residents would be signing the arbitration agreement as well. She stated they explained the arbitration agreement during the admission process. The US FOIA (b)(6) was asked if per the facility's Arbitration Agreement, the facility would select the location of Arbitration and the arbitrator. She stated, "Yes." The US FOIA (b)(6) stated it was a corporate admission packet. Review of R112's admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b1 and located under the "MDS" tab of the EMR, revealed R112 scored NJ Exec out of 15 on the "Brief Interview for Mental Status (BIMS)," which indicated the resident was NJ Exec Order 26.4b1 . During an interview on 10/17/24 at 12:03 PM, R112 stated NJ Exec had signed NJ Exec Admission Agreement. NJ Exec stated the US FOIA (b)(6) had explained things, NJ Exec had NJ Exec Order 26.4b1 what	F 848	reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Administrator will be responsible for ensuring compliance.	

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 10/17/2024

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 848	Continued From page 63 they were saying, and if [NJ Exec] did not, they would explain them to [NJ Exec] R112 was asked if she remembered signing an Arbitration Agreement. She stated she did not remember that.	F 848		
F 865 SS=E	NJAC 8:39-13.1(a) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request	F 865		12/5/24

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 10/17/2024

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 865	Continued From page 64 during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:	F 865		

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 10/17/2024

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 865	Continued From page 65 §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and observations, the facility failed to maintain documentation and demonstrated evidence of its'	F 865	1. No residents were adversely affected by the alleged deficient practice.	

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 10/17/2024

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 865	Continued From page 66 ongoing Quality Assessment and Performance Improvement (QAPI) program. This failure had the potential to negatively affect 277 of 277 residents who resided at the facility. Findings include: Review of the facility's policy titled, "QAPI Plan Quality Assessment and Performance Improvement," updated 04/01/24, indicated, ". . . Optima Care Fountains maintains a coordinated quality assessment and assurance program which integrates the review activities of all nursing home programs and services to enhance the quality of life and resident care and treatment. The purpose of the QAPI at Optima Care Fountains is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers, and other partners. To do this we study, plan, analyze, and validate specific areas of improvement for positive resident care outcomes. This will allow us to realize our Vision and carry out our Mission Statement. The QAPI will meet monthly. QAPI activities and outcomes will be on the agenda of every staff meeting and shared with residents and family members through their respective council and monthly newsletter. The minutes for all meetings will be posted throughout the facility. The QAPI committee will report all activities to the governing board during regularly scheduled meetings . . ." Review of the Second Quarter QA Meeting Agenda, dated 07/18/24 and provided by the facility, revealed topics for accident/incident report, weight report, quality measures report, pharmacy report, food temperatures, lab reports, social services report, infection control, audits,	F 865	The facility's Quality Assurance Performance Improvement (QAPI) policy was updated on 10/31/2024 to reflect that QAPI minutes will not be made publicly available. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Administrator/designee began in-servicing all QAPI members on the facility's updated QAPI policy on 11/5/2024. An audit to ensure adherence to the elements of the updated QAPI policy will be conducted by the Administrator and/or designee monthly for (3) months, or until 100% compliance. 4. The Administrator/designee will review the audit results to determine if the facility is adhering to the elements of the updated QAPI policy. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Administrator will be responsible to ensure compliance.	

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 10/17/2024

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 865	Continued From page 67 and departments reports. In attendance were the US FOIA (b)(6), Assistance Director of Nursing (ADON) 3, the Medical Director, ADON1, U.S. FOIA (b) (6), US FOIA (b)(6). Observations on 10/14/24 at 4:31 PM in the South day room did not reveal any meeting minutes from QAPI or the monthly newsletter. Observations on 10/16/24 at 1:34 PM of the South dining room and activities area did not reveal any meeting minutes from QAPI or the monthly newsletter. Throughout the days of the survey, from 10/14/24 through 10/17/24, no QAPI meeting minutes were observed posted in the facility. During an interview on 10/17/24 at 4:57 PM, the US FOIA (b)(6), and ADON3, were asked for the last two quarters' QAPI meeting minutes. ADON3 stated they might have to go around to each department to gather the information. The US FOIA (b) stated they only have an agenda. The US FOIA (b) stated they do not keep meeting minutes. NJAC 8:39-33.1 NJAC 8:39-33.2	F 865		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F 867		12/5/24

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 10/17/2024

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 867	Continued From page 68	F 867		

policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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 10/17/2024

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 867	Continued From page 69 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct	F 867		

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 10/17/2024

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 867	Continued From page 70 distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to obtain feedback, use data, and take action to conduct systematic investigations and analyses of underlying causes or contributing factors of problems affecting facility-wide processes. Specifically, the facility failed to use feedback and data from resident council meetings to address food palatability concerns. This failure had the potential to affect the	F 867	1. No residents were adversely affected by the alleged deficient practice. The Registered Dietician conducted a review of the affected residents [redacted] on 11/1/2024. There was no indication that residents experienced any nutritional problems related to the facility's failure to use feedback and data for conducting	

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 10/17/2024

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 867	Continued From page 71 nutritional status of 273 of 273 residents who ate food from the kitchen. Findings include: Review of the facility's policy titled, "QAPI Plan Quality Assessment and Performance Improvement," updated 04/01/24, indicated, "Optima Care Fountains maintains a coordinated quality assessment and assurance program which integrates the review activities of all nursing home programs and services to enhance the quality of life and resident care and treatment. The purpose of the QAPI at Optima Care Fountains is to take a proactive approach to continually improving the way we care for and engage with our residents, caregivers, and other partners. To do this we study, plan, analyze, and validate specific areas of improvement for positive resident care outcomes. This will allow us to realize our Vision and carry out our Mission Statement." Review of the Resident Council Meeting minutes, dated October 2023 through October 2024, revealed residents lodged complaints about food palatability and temperatures during eight of 12 meetings. Review of a sample meal tray revealed the food was cold and was not palatable. (Cross-Reference F804) Review of the second quarter QA Meeting Agenda, dated07/18/24, revealed topics for accident/incident report, weight report, quality measures report, pharmacy report, food temperatures, lab reports, social services report, infection control, audits, and departments reports. In attendance were the[redacted] Assistant Director of Nursing	F 867	systematic investigations and analyses. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Food Service Director will report feedback and data received from the Resident Council meetings and from the newly established Resident Food Preferences Committee to the quarterly QAPI committee. An audit will be conducted monthly for (3) months or until 100% compliance, by the Administrator and/or designee to ensure feedback and data are are being used in the development of Performance Improvement Plans. 4. The Administrator/designee will review the audit results to determine if the facility is adhering to the elements of the updated QAPI policy. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Administrator will be responsible to ensure compliance.	

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 10/17/2024

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 867	Continued From page 72 (ADON)3, the US FOIA (b)(6) , ADON1, US FOIA (b)(6) [redacted] During an interview on 10/17/24 at 4:57 PM, the US FOIA (b)(6) , and ADON3, were asked about the concerns that had been made by the residents regarding food palatability. The US FOIA (b) revealed, "Food service is not my department. That would be up to the US FOIA (b)(6) to create the root cause and an action plan to handle that." The US FOIA (b) stated, "I'm not sure what plans or measures are in place." ADON3 stated that residents are always complaining about the food, it was just an ongoing issue, and "you can't please everyone.". When asked about the prioritizing opportunities for improvement and determining which performance improvement projects were initiated, the group made no response. When asked what had been done about providing a solution for residents or a response to the grievances related to food palatability, the group made no response. NJAC 8:39-33.1 NJAC 8:39-33.2	F 867		
F 880 SS=D	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	F 880		12/5/24

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 10/17/2024

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 880	Continued From page 73 diseases and infections. §483.80(a) Infection prevention and control program. 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 §483.71 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	F 880		

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 10/17/2024

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 880	Continued From page 74 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 (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, record review, interview, and review of facility policy, the facility failed to ensure staff donned the appropriate personal protective equipment (PPE) when providing direct care to two of 13 residents (Resident (R) 110 and R157) on NJ Exec Order 26.4b1 ([redacted] out of a total sample of 48. This failure could promote the spread of NJ Exec Order 26.4b1 [redacted] throughout the facility. Findings include: Review of the facility's policy titled, "Enhanced Barrier Precautions," dated 04/01/24, revealed, ". . . All staff must wear gloves and gowns during high-contact activities for residents identified. Examples of high-contact activities are: Dressing, Bathing/showering, Transferring, Providing	F 880	1. Residents R110 and R157 were assessed by the US FOIA (b)(6) [redacted] on NJ Exec Order 26.4b1 to determine the impact of CNA 20 and CNA 3 not donning the appropriate personal protective equipment (PPE) when providing [redacted] care. NJ Exec Order 26.4b1 were identified. CNA 20 and CNA 3 were re-educated by the Staff Educator on 10/18/2024. 2. All residents on Enhanced Barrier Precautions (EBP) have the potential to be affected by the same alleged deficient practice. 3. The Staff Educator began re-educating	

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 10/17/2024

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 880	Continued From page 75 hygiene, Changing linens, Changing briefs or assisting with toileting, Device are or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care: any skin opening requiring a dressing . . ." 1. Review of R110's "Admission Record," located under the "Profile" tab of the EMR, revealed R110 was admitted to the facility on [NJ Exec Order 26.4b] with diagnoses including NJ Exec Order 26.4b1 [redacted]. Review of R110's EMR revealed R110 had an [NJ Exec Orde] NJ Exec Order 26.4b1 [redacted] During an observation on 10/14/24 at 2:50 PM, a sign was noted outside R110's door that indicated the resident was on [NJ Exec Orde] Certified Nursing Assistants (CNA) 3 and CNA20 were observed providing [NJ Ex Order 26.4(b)1] care for R110. They did not have gowns on. During the care, both CNAs held soiled linens against their uniforms. During an interview on 10/14/24 at 3:15 PM, CNA 3 and CNA 20 confirmed they were aware R110 was on [NJ Exec Or] due to [NJ Exec Order 26.4b1]. They stated they had not used protective gowns as it was the end of their shift, and they were just helping the next shift out by providing care for R110. 2. Review of R157's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R157 was admitted to the facility on [NJ Exec Order 26.4b] with diagnoses that included NJ Exec Order 26.4b1 [redacted]. During an observation on 10/15/24 at 1:36 PM, R157 was observed to have a NJ Exec Order 26.4b1 [redacted].	F 880	all staff on EBP protocols on 11/6/2024. An EBP-PPE audit of (10) staff will be conducted by the Director of Nursing and/or designee weekly for (4) weeks, or until 100% compliance to ensure staff are following EBP protocols. 4. The Director of Nursing/designee will review the audit results to determine if staff are following EBP protocols. The results of these audits will be reported to the facility's quarterly Quality Assurance Performance Improvement committee to identify trends and concerns. The Director of Nursing will responsible to ensure compliance.	

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 10/17/2024

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 880	Continued From page 76 During an observation on 10/17/24 at 8:25 AM, a sign was noted outside R157's door that indicated the resident was on [NJ Exec Orde] CNA19 and CNA21 were observed providing a bed bath for R157. They did not wear gowns during the care. CNA21 was observed holding soiled linens against her uniform. During an interview on 10/17/24 at 8:45 AM, CNA19 and CNA21 stated they were aware R157 was on [NJ Exec Or] in place due [NJ Exec Order 26.4b1]. They stated they had forgotten to put on gowns prior to the care. CNA21 stated she had just gone into the room to help, so she did not feel she had to put on a gown. CNA21 stated she had not seen the [NJ Exec Or] signage outside of R157's door. During an interview on 10/17/24 at 5:30 PM, the [US FOIA (b)(6)] confirmed all residents who needed [NJ Exec Or] had the proper signage and supplies outside of their doors. The [US] confirmed the CNAs had received education on the proper procedure for [NJ Exec Orde] NJAC 8:39-19.4	F 880		

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 10/17/2024

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) COMPLETE DATE
S 000	Initial Comments 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 the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: 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 at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. There were no reported negative outcome as a result of this alleged deficient practice. 2. All the residents have the potential to be affected by the same alleged deficient practice. 3. This facility recognizes the shortage of CNAs during the 6 of 21 day shifts from 7/23/2023 to 8/12/2023, the 3 of 14 day shifts from 8/20/2023 to 9/2/2023, 4 of of 14 day shifts from 12/31/2023 to 1/13/2024, the 9 of 14 days shifts from 2/18/2024 to 3/2/2024, the 19 of 28 days shifts from 6/23/2024 to 7/20/2024, the 19	12/5/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/08/24

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 10/17/2024

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) COMPLETE DATE
S 560	Continued From page 1 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. 1. For the 3 weeks of Complaint staffing from 07/23/2023 to 08/12/2023, the facility was deficient in CNA staffing for residents on 6 of 21 day shifts as follows: -07/25/23 had 32 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/26/23 had 33 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/27/23 had 30 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/28/23 had 30 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/29/23 had 32 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/30/23 had 32 CNAs for 272 residents on the day shift, required at least 34 CNAs. 2. For the 2 weeks of Complaint staffing from 08/20/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows:	S 560	of 28 day shifts from 8/18/2024 to 9/14/2024 and the 12 of 14 days shifts from 9/29/2024 to 10/12/2024. The facility will continue to utilize staffing agencies to fill open shifts. The facility will continue to offer overtime and bonus incentives to our current working staff. The facility's sign-on and referral bonus programs were restructured on 11/15 to increase potential referrals. The facility is in the process of hiring a Recruiter to focus on nursing staff recruitment and retention. 4. The Director of Nursing/designee will review the facility's daily staffing for adequacy and compliance with the staffing regulations. Staffing trends and patterns will be submitted to the facility's quarterly Quality Assurance and Performance Improvement committee for compliance monitoring.	

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 10/17/2024

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) COMPLETE DATE
S 560	Continued From page 2 -08/26/23 had 33 CNAs for 271 residents on the day shift, required at least 34 CNAs. -08/27/23 had 26 CNAs for 271 residents on the day shift, required at least 34 CNAs. -08/29/23 had 33 CNAs for 270 residents on the day shift, required at least 34 CNAs. 3. For the 2 weeks of Complaint staffing from 12/31/2023 to 01/13/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -01/02/24 had 29 CNAs for 260 residents on the day shift, required at least 32 CNAs. -01/03/24 had 29 CNAs for 260 residents on the day shift, required at least 32 CNAs. -01/07/24 had 30 CNAs for 258 residents on the day shift, required at least 32 CNAs. -01/08/24 had 31 CNAs for 258 residents on the day shift, required at least 32 CNAs. 4. For the 2 weeks of Complaint staffing from 02/18/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -02/21/24 had 31 CNAs for 255 residents on the day shift, required at least 32 CNAs. -02/23/24 had 31 CNAs for 262 residents on the day shift, required at least 33 CNAs. -02/24/24 had 21 CNAs for 262 residents on the day shift, required at least 33 CNAs. -02/26/24 had 31 CNAs for 265 residents on the day shift, required at least 33 CNAs. -02/27/24 had 32 CNAs for 265 residents on the day shift, required at least 33 CNAs. -02/28/24 had 31 CNAs for 265 residents on the day shift, required at least 33 CNAs.	S 560		

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 10/17/2024

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) COMPLETE DATE
S 560	Continued From page 3 -02/29/24 had 32 CNAs for 265 residents on the day shift, required at least 33 CNAs. -03/01/24 had 32 CNAs for 265 residents on the day shift, required at least 33 CNAs. -03/02/24 had 31 CNAs for 265 residents on the day shift, required at least 33 CNAs. 5. For the 4 weeks of Complaint staffing from 06/23/2024 to 07/20/2024, the facility was deficient in CNA staffing for residents on 19 of 28 day shifts as follows: -06/23/24 had 27 CNAs for 265 residents on the day shift, required at least 33 CNAs. -06/24/24 had 30 CNAs for 263 residents on the day shift, required at least 33 CNAs. -06/25/24 had 32 CNAs for 263 residents on the day shift, required at least 33 CNAs. -06/26/24 had 29 CNAs for 263 residents on the day shift, required at least 33 CNAs. -06/27/24 had 30 CNAs for 263 residents on the day shift, required at least 33 CNAs. -06/28/24 had 29 CNAs for 263 residents on the day shift, required at least 33 CNAs. -06/29/24 had 28 CNAs for 263 residents on the day shift, required at least 33 CNAs. -06/30/24 had 22 CNAs for 264 residents on the day shift, required at least 33 CNAs. -07/01/24 had 30 CNAs for 262 residents on the day shift, required at least 33 CNAs. -07/02/24 had 32 CNAs for 262 residents on the day shift, required at least 33 CNAs. -07/03/24 had 30 CNAs for 262 residents on the day shift, required at least 33 CNAs. -07/05/24 had 32 CNAs for 264 residents on the day shift, required at least 33 CNAs. -07/06/24 had 32 CNAs for 263 residents on the day shift, required at least 33 CNAs. -07/08/24 had 32 CNAs for 263 residents on the day shift, required at least 33 CNAs.	S 560		

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 10/17/2024

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) COMPLETE DATE
S 560	Continued From page 4 -07/13/24 had 31 CNAs for 260 residents on the day shift, required at least 32 CNAs. -07/14/24 had 23 CNAs for 262 residents on the day shift, required at least 33 CNAs. -07/15/24 had 30 CNAs for 261 residents on the day shift, required at least 33 CNAs. -07/16/24 had 32 CNAs for 261 residents on the day shift, required at least 33 CNAs. -07/20/24 had 30 CNAs for 263 residents on the day shift, required at least 33 CNAs. 6. For the 4 weeks of Complaint staffing from 08/18/2024 to 09/14/2024, the facility was deficient in CNA staffing for residents on 19 of 28 day shifts as follows: -08/20/24 had 32 CNAs for 265 residents on the day shift, required at least 33 CNAs. -08/22/24 had 30 CNAs for 265 residents on the day shift, required at least 33 CNAs. -08/23/24 had 30 CNAs for 265 residents on the day shift, required at least 33 CNAs. -08/24/24 had 32 CNAs for 271 residents on the day shift, required at least 34 CNAs. -08/25/24 had 25 CNAs for 271 residents on the day shift, required at least 34 CNAs. -08/26/24 had 31 CNAs for 270 residents on the day shift, required at least 34 CNAs. -08/30/24 had 33 CNAs for 270 residents on the day shift, required at least 34 CNAs. -09/01/24 had 28 CNAs for 272 residents on the day shift, required at least 34 CNAs. -09/02/24 had 30 CNAs for 271 residents on the day shift, required at least 34 CNAs. -09/03/24 had 29 CNAs for 270 residents on the day shift, required at least 34 CNAs. -09/04/24 had 30 CNAs for 270 residents on the day shift, required at least 34 CNAs. -09/05/24 had 31 CNAs for 270 residents on the day shift, required at least 34 CNAs.	S 560		

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 10/17/2024

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) COMPLETE DATE
S 560	Continued From page 5 -09/06/24 had 29 CNAs for 270 residents on the day shift, required at least 34 CNAs. -09/07/24 had 31 CNAs for 267 residents on the day shift, required at least 33 CNAs. -09/08/24 had 22 CNAs for 267 residents on the day shift, required at least 33 CNAs. -09/09/24 had 30 CNAs for 267 residents on the day shift, required at least 33 CNAs. -09/11/24 had 32 CNAs for 267 residents on the day shift, required at least 33 CNAs. -09/12/24 had 31 CNAs for 269 residents on the day shift, required at least 34 CNAs. -09/13/24 had 32 CNAs for 269 residents on the day shift, required at least 34 CNAs. 7. For the 2 weeks of staffing prior to survey from 09/29/2024 to 10/12/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -09/29/24 had 30 CNAs for 275 residents on the day shift, required at least 34 CNAs. -09/30/24 had 32 CNAs for 274 residents on the day shift, required at least 34 CNAs. -10/01/24 had 33 CNAs for 273 residents on the day shift, required at least 34 CNAs. -10/02/24 had 32 CNAs for 273 residents on the day shift, required at least 34 CNAs. -10/03/24 had 32 CNAs for 273 residents on the day shift, required at least 34 CNAs. -10/04/24 had 32 CNAs for 273 residents on the day shift, required at least 34 CNAs. -10/05/24 had 32 CNAs for 275 residents on the day shift, required at least 34 CNAs. -10/06/24 had 26 CNAs for 275 residents on the day shift, required at least 34 CNAs. -10/07/24 had 32 CNAs for 272 residents on the day shift, required at least 34 CNAs. -10/08/24 had 33 CNAs for 270 residents on the day shift, required at least 34 CNAs.	S 560		

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 10/17/2024

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) COMPLETE DATE
S 560	Continued From page 6 -10/10/24 had 33 CNAs for 270 residents on the day shift, required at least 34 CNAs. -10/12/24 had 32 CNAs for 272 residents on the day shift, required at least 34 CNAs.	S 560		

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 _____	R-C 12/12/2024

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 An onsite revisit was conducted on 12/12/2024. The facility was found to be in compliance with the implementation of their Plan of Correction.	{F 000}		

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

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.

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	12/12/2024 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 F0584	Correction	ID Prefix F0585	Correction	ID Prefix F0600	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.12(a)(1)	Completed
LSC	12/05/2024	LSC	12/05/2024	LSC	12/05/2024
ID Prefix F0609	Correction	ID Prefix F0610	Correction	ID Prefix F0761	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	12/05/2024	LSC	12/05/2024	LSC	12/05/2024
ID Prefix F0804	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/05/2024	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	

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	
10/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315476 Y1	A. Building B. Wing Y2	12/12/2024 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 F0550	Correction	ID Prefix F0583	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	12/05/2024	LSC	12/05/2024	LSC	12/05/2024
ID Prefix F0585	Correction	ID Prefix F0600	Correction	ID Prefix F0609	Correction
Reg. # 483.10(j)(1)-(4)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	12/05/2024	LSC	12/05/2024	LSC	12/05/2024
ID Prefix F0610	Correction	ID Prefix F0625	Correction	ID Prefix F0686	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.25(b)(1)(i)(ii)	Completed
LSC	12/05/2024	LSC	12/05/2024	LSC	12/05/2024
ID Prefix F0697	Correction	ID Prefix F0761	Correction	ID Prefix F0804	Correction
Reg. # 483.25(k)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	12/05/2024	LSC	12/05/2024	LSC	12/05/2024
ID Prefix F0812	Correction	ID Prefix F0847	Correction	ID Prefix F0848	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(m)(1)(2)(i)(ii)(3)-(5)	Completed	Reg. # 483.70(m), 483.70(m)(2)(iii)(iv)(6)	Completed
LSC	12/05/2024	LSC	12/05/2024	LSC	12/05/2024

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

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	12/12/2024 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 F0865	Correction	ID Prefix F0867	Correction	ID Prefix F0880	Correction
Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed	Reg. # 483.75(c)(d)(e)(g)(2)(i)(ii)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	12/05/2024	LSC	12/05/2024	LSC	12/05/2024

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?
10/17/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
60918	A. Building B. Wing	12/12/2024

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 12/05/2024	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
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

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 10/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: PH7412

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
60918	A. Building B. Wing	12/12/2024

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 12/05/2024	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
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

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 10/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING **01** B. WING _____	**10/17/2024**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/15/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 10/15/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Optima Care Fountains is a two-story building built in 1924. It is composed of Type II protected construction. The facility is divided into sixteen - smoke zones. The generator does approximately 75% of the building per Maintenance Director. The current occupied beds are 276 of 324.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6.	K 311		12/5/24

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

Electronically Signed | 11/08/2024

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
	315476	A. BUILDING **01** B. WING _____	**10/17/2024**

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
K 311	Continued From page 1 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 interview, the facility failed to ensure four out of four stairway door assemblies on Units 11 and 12 latched when closed; and failed to ensure five stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.8.1. and Section 7.2.1.7.2. This deficient practice had the potential to affect all 276 residents who resided at the facility. Findings include: Observations on 10/15/24 at 3:41 PM of the stairway fire door assemblies located on the first and second floors revealed the Unit 11 doors would not latch when closed. Observations at 3:50 PM revealed the Unit 12 doors did not latch when closed. An observation on 10/10/24 at 1:11 PM revealed the stairway exit door on the Unit 9 basement was equipped with panic hardware. An observation at 4:09 PM revealed stairway one's exit door in the South Building on the ground level was equipped with panic hardware. An observation at 4:11 PM revealed the stairway two exit door in the South Building on the ground level was equipped with panic hardware.	K 311	1. New latches were ordered for the (4) stairway doors and new fire rated panic hardware assemblies were ordered for the (5) stairway exit doors. 2. All residents have the potential to be effected by the same alleged deficient practice. 3. An audit of all stairwell doors was conducted by the Maintenance Director/designee to ensure they latched and when applicable, were equipped with approved fire exit hardware. 4. An annual audit of all stairwell doors will be conducted by the Maintenance Director/designee to ensure they latch and when applicable, are equipped with approved fire exit hardware. The results of these audits will be reviewed quarterly by the Quality Assurance Performance Improvement Committee for trends and concerns. The Maintenance Director is responsible for ensuring compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING **01** B. WING _____	**10/17/2024**

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
K 311	Continued From page 2 An observation at 4:29 PM revealed the stairway three exit door in the South Building on the ground level was equipped with panic hardware. An observation at 4:37 PM revealed the stairway four exit door in the South Building second floor was equipped with panic hardware. Panic hardware is only permitted on non-fire rated door assemblies and fire exit hardware was required on all fire rated door assemblies. During an interview at the time of observations, the Maintenance Director confirmed the stairway fire doors did not latch in Units 11 and 12 and the stairway fire doors in the South Building were equipped with panic hardware. NJAC 8:39-31.2(e) NFPA 80	K 311		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		12/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING **01** B. WING _____	**10/17/2024**

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
K 324	Continued From page 3 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the automatic extinguishing system was tested semi-annually in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 edition), Section 11.2. This deficient practice had the potential to affect all 276 residents who resided at the facility. Findings include: A review of the facility's "Kitchen Automatic Fire System Reports," provided by the facility, revealed the fire-extinguishing system was inspected on 08/19/24. The facility did not have a report for February 2024 indicating that the system had been inspected in the prior six months. An observation on 10/15/24 at 4:20 PM of the automatic extinguishing system revealed the inspection tag that was placed on the pull station near the automatic extinguishing system was dated for August 2024.	K 324	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. An inspection on the facility's automatic extinguishing system was scheduled for February 5, 2025 to ensure the system is inspected semi-annually. The facility will pre-schedule all future inspections of their automatic extinguishing system to ensure the system is inspected semi-annually. 4. A quarterly audit of the facility's automatic extinguishing system inspection will be conducted by the Maintenance Director/designee to ensure the system is inspected semi-annually. The results of these audits will be reviewed quarterly by the Quality Assurance Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING 01 B. WING _____	10/17/2024

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
K 324	Continued From page 4 During an interview at the time of observation, the Maintenance Director confirmed the kitchen's automatic fire-extinguishing system was not inspected in February 2024 or in the prior six months prior to the August 2024 inspection. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	Committee for trends and concerns. The Maintenance Director is responsible for ensuring compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the Fire Alarm System was tested semi-annually in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Sections 14.4.5. This deficient practice had the potential to affect all 276 residents who resided at the facility. Findings include: A review of the facility's untitled fire safety binder provided by the US FOIA (b)(6) revealed no documented evidence the fire alarm system was tested in 2024. Continued review revealed the last report in the binder was dated February 2023.	K 345	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. An inspection on the facility's fire alarm system was scheduled for November 2024 to ensure the system is inspected semi-annually. The facility will pre-schedule all future inspections of their fire system to ensure the system is inspected semi-annually.	12/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING 01 B. WING _____	10/17/2024

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
K 345	Continued From page 5 Observations on 10/15/24 from 12:00 PM to 5:15 PM revealed the smoke detectors were in the corridors. During an interview at the time of the observation, the U.S. FOIA (b) (6) stated that he had been trying to get the fire alarm company to come out to conduct the test on the fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 345	4. A quarterly audit of the facility's fire alarm system inspection will be conducted by the Maintenance Director/designee to ensure the system is inspected semi-annually. The results of these audits will be reviewed quarterly by the Quality Assurance Performance Improvement Committee for trends and concerns. The Maintenance Director is responsible for ensuring compliance.	
K 351 SS=F	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 observations and interview, the facility	K 351	1. No residents were affected by this	12/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING 01 B. WING _____	10/17/2024

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
K 351	Continued From page 6 failed to ensure the two walk-in coolers had sprinkler coverage in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) Section 8.1. This deficient practice had the potential to affect all 276 residents who resided at the facility. Findings include: Observations on 10/15/24 at 4:29 PM revealed that walk-in two coolers located on the first level of the South Building did not have sprinkler coverage. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the coolers did not have sprinkler coverage. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	alleged deficient practice. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The installation of the (2) sprinkler heads for the (2) coolers was scheduled. 4. A semi-annual audit of the facility's coolers will be conducted by the Maintenance Director/designee to ensure sprinkler coverage is in place. The results of these audits will be reviewed quarterly by the Quality Assurance Performance Improvement Committee for trends and concerns. The Maintenance Director is responsible for ensuring compliance.	
K 352 SS=F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure sprinkler tamper switches were	K 352	1. No residents were affected by this alleged deficient practice.	12/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING **01** B. WING _____	**10/17/2024**

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
K 352	Continued From page 7 monitored by the fire alarm system in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.5.1. This deficient practice had the potential to affect all 276 residents who resided at the facility. Findings include: Observations on 10/15/24 at 12:57 PM revealed the sprinkler seven tamper switches were not connected to the fire alarm system. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the sprinkler tamper switches were disconnected from the fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25. 72	K 352	2. All residents have the potential to be affected by the same alleged deficient practice. 3. An appointment was scheduled with the facility's fire alarm vendor to connect the sprinkler tamper switches to the fire alarm system. 4. A semi-annual audit of the facility's sprinkler tamper switches will be conducted by the Maintenance Director/designee to ensure they are connected the fire alarm system. The results of these audits will be reviewed quarterly by the Quality Assurance Performance Improvement Committee for trends and concerns. The Maintenance Director is responsible for ensuring compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		12/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING 01 B. WING _____	10/17/2024

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
K 761	Continued From page 8 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interview, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 276 residents who resided at the facility. Findings include: A review of the facility's untitled fire safety binder provided by the US FOIA (b)(6) revealed no documented evidence that the facility's fire doors were inspected. Observations on 10/15/24 from 12:00 PM to 5:15 PM of the facility's fire doors revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of each observation, the US FOIA (b)(6) confirmed the fire doors had not been inspected annually. NJAC 8:39-31.2(e) NFPA 80	K 761	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. An inspection of the facility's fire door was conducted by the Maintenance Director. The US FOIA (b)(6) was in-serviced on the requirement that all fire doors be inspected annually by an individual that can demonstrate the knowledge and understanding of the door's operating components. 4. A semi-annual audit of the facility's door inspections will be conducted conducted by the Maintenance Director/designee to ensure the facility's fire doors are being inspected annually by an individual that can demonstrate the knowledge and understanding of the door's operating components. The results of these audits will be reviewed quarterly by the Quality Assurance Performance Improvement Committee for trends and concerns. The Maintenance Director is responsible for ensuring compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING 01 B. WING _____	10/17/2024

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
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure electrical outlet testing was conducted annually in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. This deficient practice had the potential to affect all 276 residents who resided at the facility. Findings include: A review of the facility's fire inspection binder provided by the US FOIA (b)(6) revealed the electrical outlet testing was not completed on	K 914	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. An inspection of the facility's electrical outlets was conducted by the Maintenance Director. The U.S. FOIA (b) (6) was in-serviced on the requirement that all electrical	12/5/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315476	A. BUILDING **01** B. WING _____	**10/17/2024**

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
K 914	Continued From page 10 the electrical outlets in the past year. During an interview on 10/15/24 at 12:30 PM, the US FOIA (b)(6) stated that the electrical outlet testing was not completed annually. NJAC 8:39-31.2(e) NFPA 70, 99	K 914	outlets must be inspected annually. 4. A semi-annual audit of the facility's electrical outlet inspections will be conducted by the Maintenance Director/designee to ensure the facility's electrical outlets are being inspected annually. The results of these audits will be reviewed quarterly by the Quality Assurance Performance Improvement Committee for trends and concerns. The Maintenance Director is responsible for ensuring compliance.	

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 01 - HUDSON MANOR B. Wing Y2	12/12/2024 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	12/05/2024	LSC K0324	12/05/2024	LSC K0345	12/05/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	12/05/2024	LSC K0352	12/05/2024	LSC K0761	12/05/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0914	12/05/2024	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	

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	
10/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO