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	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optima Care Fountains	505 County Avenue Secaucus, NJ 07094

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 49509 Complaint #: NJ00181722, NJ00181697 Based on observation, interview, record review and review of other pertinent facility documents on 1/16/2025, 1/17/2025 and 1/22/2025, it was determined that the facility failed to provide adequate supervision to ensure a safe environment for a cognitively impaired, exit seeking resident. The facility failed to ensure exit doors were secured to prevent the resident's exit from the unit. This resulted in Resident #2 eloping from the nursing unit on 12/13/2024. This deficient practice was identified for 1 of 1 resident (Resident #2) reviewed for elopement. The facility failed to ensure a safe environment for Resident #2, posed a serious and immediate risk to the health, safety and wellbeing of the resident. The findings were as follows: The New Jersey Department of Health received a Facility Reportable Event (FRE) dated 12/19/24 at 10:51a.m. According to the FRE, on 12/13/24, at approximately 11:15 p.m., a nurse conducting rounds noticed that Resident #2 was not in the room. After searching the unit, the nurse called a Code Gray, alerting all staff of the missing resident. After searching the entire facility and perimeter, 911 was called. The resident could not be found at that time. On 12/14/24, at approximately 7:00 a.m. while conducting rounds, a nurse heard a loud voice coming from the attic asking for help. Resident #2 was found in the attic. The staff assisted Resident #2 down from the attic. The resident was noted with redness to the forehead. Resident #2 was sent to the emergency room for further evaluation. Upon returning from the hospital on 12/14/2025 Resident #2 was assigned 1 staff member to supervise the resident each shift (7:00 a.m.-3:00 p.m.; 3:00 p.m.-11:00 p.m. and 11:00 p.m.-7:00 a.m.) According to the facility this is a 1:1 staff to resident assignment. According to the Admission Record (AR), Resident #2 was admitted to the facility with diagnoses which included but were not limited to: Unspecified Dementia with Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. The resident's primary language is Spanish. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to the Minimum Data Set (MDS), an assessment tool, dated 11/04/2024, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13/15, which indicated that the Resident's cognition is intact. The MDS also indicated Resident #2 is independent with most Activities of Daily Living (ADLs). A review of the Resident's Care Plan (CP) initiated on 11/04/2024 with a revision date of 12/18/2024 revealed under Focus: [Resident] is an elopement risk/wanderer, [Resident] is new to the facility, verbalizing wanting to leave or go home. A second Focus dated 12/13/2024 documented attempted elopement. The Goal included [Resident] will not leave facility unattended through the review date. The CP interventions dated 11/04/2024 included but was not limited to: Assess for fall risk, assess risk for elopement on admission and change in condition and quarterly, distract Resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers. Document wandering behavior and attempted diversional intervention in behavior log. Place picture at reception desk and provide structured activities: toileting, reorientation strategies including signs and picture. Interventions dated 11/07/2024 included 15 minute check; 11/06/2024: transferred to a locked unit. Interventions dated 12/14/2024 included: assessment for pain and injury; transferred to ER (emergency room) for evaluation; 1:1 monitoring after hospital evaluation; psychosocial evaluation by social worker to ensure wellbeing. On 1/16/2025 at 10:43 a.m., the Surveyor entered unit 11 and observed Resident #2 with an assigned staff member. The surveyor interviewed the Unit Manager (UM) stated three weeks ago Resident #2 went through the exit door by the nurse's station and was found in the ceiling attic which is in the stairway. She further stated, all residents are allowed to go upstairs, ambulatory residents can go up and down the steps through the unsecured door by themselves. On 1/16/2025 at 12:00 p.m., the Surveyor toured unit 11 with the Assistant Director of Nursing (ADON). The surveyor observed an exit door down the hallway which had a sign that read: stop door has alarm do not push in English and Spanish. The surveyor also observed a sign: exit door facing the nurse's station on unit 11. The ADON stated the exit door is used for the residents on the unit 12. The surveyor observed a ladder leading to the attic on the second floor. A sign was posted: danger do not climb on ladder in English and Spanish. The ADON further stated Resident #2 attempted to leave the facility on 11/06/2024, was found at the receptionist desk. On 11/08/2024 resident was transfer from unit 9 to unit 11 locked unit. On 1/17/2025 at 10:40 a.m., the Surveyor interviewed the Director of Maintenance (DM) who stated he was made aware of the incident on 12/16/2024 upon arrival to the facility. The DM went on second floor and observed the attic door was unsecured. On 1/17/2025 at 11:08 a.m., the Surveyor observed a lock applied to the ladder preventing it from being pulled down and preventing resident access to the ladder and attic. On 1/17/2025 at 1:00 p.m., the Surveyor observed resident #2 in his/her room with the assigned Certified Nurse's Aide (CNA) for this shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 1/17/2025 at 1:40 p.m., the Surveyor interviewed Certified Nurse's Aide (CNA) #2 who was aware of the incident on 12/13/2024. The CNA further stated upon arrival on unit 11 while making rounds, she heard the nurse state Resident #2 was missing. The staff searched for the resident throughout the building and outside of the building. Police were summoned and were also searching for the resident. The Resident was found over seven hours later in the attic. On 1/17/2025 at 2:30 p.m., the Surveyor attempted to contact 3 staff members involved in the care of Resident #2. The CNA caring for the resident on the 3-11 shift, another CNA caring for the resident on the 11-7 shift and an LPN were not able to be reached for interview despite the surveyor's attempts. On 1/22/2025 at 10:33 a.m., the Surveyor observed residents and staff from unit 11 going through an unsecured door onto the stairway to unit 12. According to the DM during an interview with the surveyor on 1/22/2025 at 11:07 a.m., the exit door that leads to the second floor has a keypad that does not work. The exit door allows the residents to use the stairs when they want to. On 1/22/2025 at 11:10 a.m., the Surveyor interviewed the ADON who stated unit 11 and 12 are locked units however, the door was not secured. The ADON further stated the residents go up and down from the second floor to the first floor through this unsecured door. The facility was unable to provide evidence that the unit door was secured. Review of an undated facility policy titled; Elopement Policy, included the following: Under: Policy Statement: This Facility ensures that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement. The facility was notified of the IJ situation on 1/22/25 at 4:52 p.m. The Director of Nursing (DON) was presented with the IJ template. The Administrator was not available to attend. An acceptable removal plan was electronically mailed to the surveyor on 1/28/2025 at 5:30 p.m. indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice. The surveyor verified the removal plan during an onsite revisit 1/30/2025 and determined the Immediate Jeopardy for F689 was removed as of 1/22/2025. The Removal Plan is as follows: 1. The facility implemented 24/7 monitoring of Unit 11's stairwell door from the first floor to ensure that Residents at risk of wandering and elopement will have the necessary supervision for preventing unsafe access to the stairwell door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The Administrator reviewed the daily staffing sheet for 1/30/2025 with surveyor for Unit 11 section which contained: 1 nurse, 4 CNAs and 2 Behavioral Specialists (BSPEC) The role of the BSPEC is to monitor the door. Further review of the daily staffing noted 3-11 shift 1 BSPEC and 11-7 shift 1 BSPEC. An Elopement Binder was put in place for high-risk Residents including photos of residents who are not allowed upstairs. 3. Initiating in-services for all staff on the facility's policy on Elopement and Wandering. The Immediate Jeopardy began on 12/13/2024 to 1/22/2024 and was lowered to no actual harm with the potential for more than minimal harm that is not an Immediate Jeopardy. N.J.A.C 8:39: 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50919 Complaint #: NJ00182050 Based on interviews, review of medical records, and other pertinent facility documentation on 1/16/2025 and 1/17/2025, it was determined that the facility failed to: a.) administer medications as prescribed within the appropriate medication administration timeframe and b.) notify the physician when a medication was not available for administration. The facility also failed to follow its policy titled Medication Administration Policy. This deficient practice was identified for 2 of 3 residents reviewed for medication administration documentation. This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [DATE], with diagnoses that included but were not limited to: Parkinson's Disease, Unspecified Dementia, and Unspecified Depression. A review of Resident #1's Minimum Data Set (MDS), an assessment tool dated 10/12/2024, revealed a Brief Interview of Mental Status (BIMS) of 14 out of 15, which indicated the resident's cognition was intact. A review of Resident #1's Order Summary Sheet (OSR) with active orders as of 12/1/2024 revealed the following medication orders: Ativan 0.5 milligrams (mg)-give one tablet by mouth every 12 hours with an active order date of 04/07/2024. Carbidopa-Levodopa 25-100mg-give one tablet by mouth three times a day with an active order date of 04/05/2024. Mirtazapine 7.5mg-give one tablet by mouth at bedtime with an active order date of 04/05/2024. Rosuvastatin Calcium 10mg- give one tablet by mouth in the evening with an active order date of 07/29/2024. A review of Resident #1's Medication Administration Record (MAR) for December 2024 revealed a code of NN for Ativan 0.5mgs at 8:00 PM, Carbidopa-Levodopa 25-100mg at 9:00 PM, Mirtazapine 7.5mgs at 9:00 PM, and Rosuvastatin Calcium 10mg at 10:00 PM on 12/9/2024, 12/12/2024, 12/19/2024, 12/22/2024 at 9:00 PM. Further review of the MAR revealed that code NN meant other/see nurse notes. A review of Resident #1's Progress Notes (PNs) dated 12/9/2024 at 6:43 PM, 12/12/2024 at 6:59 PM and 12/22/2024 at 6:35 PM revealed a note from the nurse that stated, due meds given. A PN dated 12/12/2024 at 6:59 PM revealed a note from the nurse that stated, meds given. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 1/16/2025 at 2:18 PM, the Assistant Director of Nursing (ADON) stated that the standard of practice was that medications should be administered an hour before or an hour after the administration time. The ADON stated that medications should not be given outside the medication administration timeframe. The ADON indicated she could not speak to why the nurse documented in the progress note that medications were administered to the resident more than one hour before the administration time. The ADON indicated that if the resident requested medications outside of the medication administration timeframe, then it was the nurse's responsibility to notify the physician to get an order to change the administration time. The ADON further stated it was important to stay within the hour before and the hour after administration timeframe to ensure there were no potential medication interactions. During a follow-up interview with the surveyor on 1/17/2025 at 11:30 AM, the ADON indicated that the code NN' on the MAR meant the nurse had to document a reason to why a medication was not given at that time. The ADON further stated that if there was a check mark on the MAR that indicated the medication was administered. 2. According to the AR, Resident #4 was admitted to the facility on [DATE], with diagnoses that included but were not limited to: Human Immunodeficiency Virus (HIV), Diabetes, and Anxiety Disorder. A review of Resident #4's MDS dated [DATE] revealed a BIMS of 8 out of 15, which indicated the resident's cognition was moderately impaired. A review of Resident #4's OSR with active orders as of 12/20/2024 revealed the following medication orders: Dolutegravir Sodium 50 mg-give one tablet by mouth one time a day for HIV with an active order date of 12/20/2024. Emtricitabine-Tenofovir Disoproxil Fumarate 200-300 mg- give one tablet by mouth one time a day for HIV with an active order date of 12/20/2024. Sitagliptin 50mg-give one tablet by mouth one time a day for diabetes with an active order date of 12/20/2024. A review of Resident #4's MAR for December 2024 revealed a code NN for the following medications: Dolutegravir Sodium 50 mg on 12/21/2024, 12/22/2024, and 12/25/2024 at 8:00 AM. Emtricitabine-Tenofovir Disoproxil Fumarate 200-300 mg and Sitagliptin 50mg on 12/25/2024 at 8:00 AM. A review of Resident #4's PN dated 12/21/2024 at 9:56 AM revealed a nurse's note that indicated Dolutegravir Sodium 50 mg was just ordered, has not arrived yet from pharmacy. PNs on 12/25/2024 at 11:07 AM, 11:08 AM, and 11:10 AM revealed a nurse's note that the medication was on order. There was no PN dated 12/22/2024 for a reason to why the medications were not given. There were no PNs which indicated the physician was notified about the medications not being available for the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 1/16/2025 at 1:42 PM, the Licensed Practical Nurse (LPN#1) stated if a medication was not delivered by the pharmacy and not in the facility back up, the nurse should have called the pharmacy and then notified the physician. LPN #1 further stated that the nurse should document in the progress notes that they contacted the physician, and the medication was not given. During an interview with the surveyor on 1/17/2025 at 11:30 AM, the ADON stated that if medications were not available, the nurse was responsible for calling the pharmacy to find out when medication would be delivered. The ADON stated the nurse would call the physician and make them aware that the medication was not available. She further stated that the nurse was responsible for documenting that the physician was made aware that a resident's medication was not available for administration. The ADON confirmed that there was no documentation in the resident's medical record that reflected the nurses' notified the physician that Resident #4's medications were not given on the dates specified. The ADON stated Resident #4's HIV medications were delivered and that it was the nurses' fault for not looking for the medications. The ADON stated she could not speak to why the nurses did not notify the physician or administer the medications that had been delivered. Review of the facility policy titled Medication Administration Policy, dated 3/2023, reflected under Policy, 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. Under Procedure, 2. Medications are to be administered in a timely manner following physician's order. 6. The licensed nurse is responsible to follow: e. follows appropriate medication administration guidelines. 18. Uses prudent professional judgement by informing physician in a timely manner when medications held, refused, or otherwise unavailable for administration. Review of the facility document titled Medication Pass Observation, revised 12/6/2019, reflected Medications are given one hour before to one hour after the charted time. NJAC 8:39-29.2 (d)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50919 Complaint #: NJ00182050 Based on interviews, medical record review, and review of other pertinent facility documents on 1/16/2025 and 1/17/2025 it was determined that the facility staff failed to consistently document in the Documentation Survey Report (DSR) the Activities of Daily Living (ADL) status and care provided to the residents. This deficient practice was identified for 3 of 3 residents reviewed for ADL documentation. This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [DATE], with diagnoses that included but were not limited to: Parkinson's Disease, Unspecified Dementia, and Unspecified Depression. A review of Resident #1's Minimum Data Set (MDS), an assessment tool dated 10/12/2024, revealed a Brief Interview of Mental Status (BIMS) of 14 out of 15, which indicated the resident's cognition was intact. The MDS further revealed that the resident was independent with toileting hygiene and dressing but requires supervision and set-up assistance with bathing and personal hygiene. A review of Resident #1's Care Plan (CP) initiated on 4/5/2024 revealed that the resident had an ADL self-care performance deficit related to weakness. A review of Resident #1's DSR (ADL Record) and the progress notes (PN) for the month of December 2024 revealed lack of documentation to indicate that the resident's ADL care was provided and/or the resident refused care on the following dates and shifts: Bed Bath: 7:00 AM- 3:00 PM shift on 12/23/2024 and 12/29/2024. Bed Mobility: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. 3:00 PM-11:00 PM shift on 12/31/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024, 12/12/2024, 12/23/2024, 12/27/2024, and 12/29/2024. Bladder and Bowel Continence: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:00 PM-11:00 PM shift on 12/31/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024, 12/12/2024, 12/23/2024, 12/27/2024, and 12/29/2024. Dressing: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. 3:00 PM-11:00 PM shift on 12/31/2024. Personal Hygiene: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. 3:00 PM-11:00 PM shift on 12/31/2024. Toilet Use: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. 3:00 PM-11:00 PM shift on 12/31/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024. 12/12/2024, 12/23/2024, 12/27/2024, and 12/29/2024. GG Mobility: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. 3:00 PM-11:00 PM shift on 12/31/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024. 12/12/2024, 12/23/2024, 12/27/2024, and 12/29/2024. GG Self Care (includes dressing, oral hygiene, personal hygiene, and toilet hygiene): 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. 3:00 PM-11:00 PM shift on 12/31/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024. 12/12/2024, 12/23/2024, 12/27/2024, and 12/29/2024. Locomotion on and off unit: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:00 PM-11:00 PM shift on 12/31/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024. 12/12/2024, 12/23/2024, 12/27/2024, and 12/29/2024. Transferring: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. 3:00 PM-11:00 PM shift on 12/31/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024. 12/12/2024, 12/23/2024, 12/27/2024, and 12/29/2024. Walk in Room/ Walk in Corridor: 7:00 AM-3:00 PM shift on 12/23/2024 and 12/29/2024. 3:00 PM-11:00 PM shift on 12/31/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024. 12/12/2024, 12/23/2024, 12/27/2024, and 12/29/2024. Eating: 7:15 AM on 12/23/2024 and 12/29/2024. 11:30 AM on 12/23/2024 and 12/29/2024. 4:30 PM on 12/31/2024. 2. According to the AR, Resident #4 was admitted to the facility on [DATE] with diagnoses that included but were not limited to: Human Immunodeficiency Virus (HIV), Diabetes, and Anxiety Disorder. A review of Resident #4's MDS dated [DATE] revealed a BIMS of 8 out of 15 which indicated the resident's cognition was impaired. The MDS further revealed that the resident needed assistance with ADLs. A review of Resident #4's CP initiated on 12/21/2024 revealed that the resident had deficits with performing ADLs related to intermittent confusion and weakness. A review of Resident #4's DSR (ADL Record) and the progress notes (PN) for the month of December 2024 revealed lack of documentation to indicate that the resident's ADL care was provided and/or the resident refused care on the following dates and shifts: Bed Bath: 7:00 AM- 3:00 PM shift on 12/29/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bed Mobility: 7:00 AM- 3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AM shift on 12/20/2024 and 12/29/2024. Bladder Continence: 7:00 AM-3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AM shift on 12/20/2024 and 12/29/2024. Toilet Use: 7:00 AM-3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AM shift on 12/20/2024 and 12/29/2024. Locomotion on Unit: 7:00 AM- 3:00 PM shift on 12/29/2024. 3:00 PM- 11:30 PM shift on 12/21/2024. 11:00 PM- 7:00 Am shift on 12/20/2024 and 12/29/2024. Personal Hygiene: 7:00 AM- 3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. Bowel Continence and Movements: 7:00 AM- 3:00 PM shift on 12/29/2024. 3:00 PM- 11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AAM shift on 12/20/2024 and 12/29/2024. Dressing: (continued on next page)

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	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optima Care Fountains	505 County Avenue Secaucus, NJ 07094

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7:00 AM-3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. GG Mobility: 7:00 AM -3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AM shift on 12/20/2024 and 12/29/2024. GG Self Care (includes dressing, oral hygiene, personal hygiene, and toilet hygiene): 7:00 AM -3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AM shift on 12/20/2024 and 12/29/2024. Locomotion on and off Unit: 7:00 AM -3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AM shift on 12/20/2024 and 12/29/2024. Transferring: 7:00 AM -3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AM shift on 12/20/2024 and 12/29/2024. Walk In Room/Walk in Corridor: 7:00 AM -3:00 PM shift on 12/29/2024. 3:00 PM-11:00 PM shift on 12/21/2024. 11:00 PM- 7:00 AM shift on 12/20/2024 and 12/29/2024. Eating: 7:15 AM on 12/29/2024. (continued on next page)

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	01/30/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:30 AM on 12/29/2024. 4:30 PM on 12/21/2024. 3. According to the AR, Resident #5 was admitted to the facility on [DATE] with diagnoses that include but were not limited to: Unspecified Dementia, Anemia, and Anxiety. A review of Resident #5's MDS dated [DATE] revealed a BIMS of 13 out of 15 which indicated the resident's cognition was intact. The MDS further revealed the resident required assistance with ADLs. A review of Resident #5's CP initiated on 09/06/2024 revealed that the resident had an ADL self-care performance deficit related to weakness and deconditioning. A review of Resident #5's DSR (ADL Record) and the progress notes (PN) for the month of December 2024 revealed lack of documentation to indicate that the resident's ADL care was provided and/or the resident refused care on the following dates and shifts: Bladder Continence: 7:00 AM- 3:00 PM shift on 12/1/2024, 12/7/2024, 12/11/2024, 12/28/2024, 12/29/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024, 12/12/2024. Bowel Continence and Movements: 7:00 AM-3:00 PM shift on 12/1/2024, 12/7/2024, 12/11/2024, 12/28/2024, and 12/29/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024, 12/12/2024. GG Mobility: 7:00 AM-3:00 PM shift on 12/1/2024, 12/7/2024, 12/11/2024, 12/28/2024, and 12/29/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024, and 12/12/2024. GG Self Care (includes dressing, oral hygiene, personal hygiene, and toilet hygiene): 7:00 AM-3:00 PM shift on 12/1/2024, 12/7/2024, 12/11/2024, 12/28/2024, and 12/29/2024. 11:00 PM- 7:00 AM shift on 12/5/2024, 12/6/2024, 12/11/2024, and 12/12/2024. Eating: 7:15 AM on 12/1/2024, 12/7/2024, 12/11/2024, 12/28/2024, and 12/29/2024. 11:30 AM on 12/1/2024, 12/7/2024, 12/11/2024, 12/28/2024, and 12/29/2024. (continued on next page)

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	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optima Care Fountains	505 County Avenue Secaucus, NJ 07094

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 1/16/2025 at 11:05 AM, the Certified Nursing Assistant (CNA #1) stated that the CNAs were responsible for documenting showers and ADL care into the Point of Care (POC), a mobile enable app that runs on wall mounted kiosks that enables care staff to document ADLs at the end of their shift. CNA #1 stated that every task on the POC must be addressed, and blank spaces were not acceptable. CNA #1 further stated that if there were a blank space on the DSR that would mean either someone did not do the task in the POC, or they had not completed the task yet. During an interview with the surveyor on 1/17/2025 at 11:30 AM, the Assistant Director of Nursing (ADON) stated the CNAs were responsible for completing all ADL documentation before the end of their shift. The ADON could not explain why there was blank spaces in the residents' DSRs. The ADON indicated that it was the CNAs, nurses, supervisor, and Unit Manager (UM) responsibility to ensure that ADL documentation was completed at the end of each shift and reflected on the DSR. The facility was unable to provide the surveyor with a policy on ADL documentation.