| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315310 | A. Building<br>B. Wing | 05/28/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Optima Care Harborview | 178-198 Ogden Ave<br>Jersey City, NJ 07307 |

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) |
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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>Complaint #: 2787834, 2997846, 3022108 Based on interviews, medical record reviews, and review of other pertinent facility documentation, it was determined that the facility failed to develop a care plan (CP) for a resident who was on enhanced barrier precautions (EBP) (infection control measures using gowns and gloves during high-contact care to prevent the spread of multidrug-resistant organisms) (Resident #1). This deficient practice was identified for 1 of 5 residents reviewed for care plans. This deficient practice was evidenced by the following:Resident #1 was no longer at the facility. A closed record review was conducted. According to the admission Record (AR), Resident #1 was admitted to the facility with diagnoses which included but were not limited to hemiplegia (one-sided paralysis), unspecified affecting nondominant side; encounter for attention to gastrostomy (an artificial external opening into the stomach for nutritional support or decompression); and need for assistance with personal care. A review of Resident #1's Comprehensive Minimum Data Set (MDS), an assessment tool dated 04/10/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated the resident's cognition was severely impaired. The MDS for Resident #1 revealed that the resident had a feeding tube present on admission. Further review of the MDS for Resident #1 revealed that the resident had surgical wounds. Review of the Order Summary Report for Resident #1 revealed an order for EBP related to the resident's percutaneous endoscopic gastrostomy (PEG) tube (device inserted through the abdominal wall into the stomach to provide nutrition, decompression, or medication administration). The order date was 04/03/2026. A review of Resident #1's CPs did not reveal a focus or interventions that addressed Resident #1's need for EBP related to their PEG tube. An interview was conducted with the Director of Nursing (DON) on 05/28/20206 at 5:45 PM. The CP for Resident #1 was reviewed with the DON. The DON stated that the purpose of the CP was to communicate appropriate interventions and tell facility staff what to do for resident safety, protection and care. The DON stated that Resident #1 was on EBP because they had a PEG tube. The DON confirmed that the need for EBP was not included in Resident #1's CP and stated that if a resident was on EBP it should have been included in their CP. The DON further stated that Unit Managers, Infection Preventionists, and the DON were all responsible for updating resident CPs. The facility policy ENHANCED BARRIER PRECAUTIONS with an effective date of 04/01/2024 and a last review date of 01/30/2026 was reviewed. Under Purpose the facility policy revealed, To prevent the spread of multi-resistant organisms in long term care settings. Under GENERAL INFORMATION: the facility policy revealed . Recent studies have indicated the use of EBP can effectively reduce the spread of MDROs [multi-drug resistant organisms]. Enhanced Barrier Precautions expand the use of PPE [personal protective equipment] and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. [ .] Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. This section of the facility policy further revealed, The following situations would warrant Enhanced Barrier Precautions: (EBP) [.] wounds and/or indwelling medical devices (regardless of their MDRO status) [.] Feeding tubes. The facility policy Resident's Baseline Care Plan with an effective date of 10/02/2024 and a last<br>(continued on next page) |

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.

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

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | reviewed date of 03/16/2026 was reviewed. Under POLICY the facility policy revealed, It is the policy of this center [sic] develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality care. Under GENERAL INFORMATION the policy revealed The Baseline care plan should include: [.] Physician's orders [.] The facility may provide a Comprehensive Care Plan in place of the Baseline care plan if the comprehensive care plan is developed within 48 hours and includes: [.] Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. NJAC 8:39-11.2 (d) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>Complaint #: 2787834, 2997846, 3022108Based on observations, interviews, record reviews, and review of pertinent facility documents it was determined that the facility failed to develop personalized care plans for 2 of 3 incontinent residents, based on the residents' preference for the use of two incontinence briefs (IB). This deficient practice was identified for 2 of 3 residents reviewed for incontinence care (Resident #2 and Resident #3). The deficient practice was evidenced by the following:Incontinence rounds (IRs) were conducted with Unit Manager (UM) #1 on the facility's fourth floor on 05/28/2026 at 10:55 AM. The Surveyor observed Resident #2 in their bed with Certified Nursing Assistant (CNA) #1 providing care. The resident was wearing a small IB which was damp with urine, inside an outer IB. UM #1 confirmed the presence of two IBs on Resident #2. During the same incontinence tour Resident #3 was observed in bed wearing two IBs. UM #2 confirmed that Resident #3 was wearing two IBs. The medical record for Resident #2 was reviewed. According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses including but not limited to: encounter for orthopedic aftercare following surgical amputation (the surgical or traumatic removal of a limb or extremity); acquired absence of left leg below knee (amputation); type 2 diabetes mellitus without complications (chronic condition in which the body cannot use insulin properly, leading to high blood sugar levels); need for assistance with personal care; and repeated falls. Review of the Care Plan (CP) for Resident #2 revealed a Focus that Resident #2 was at risk for skin impairment and had fragile skin. This focus was initiated and revised on 05/09/2026. Interventions related to this focus included: providing incontinent care as needed; and keeping the resident's skin clean and dry. Further review of the CP for Resident #2 revealed a Focus related to the resident's preference for using double diapers for their comfort and dignity. This focus was initiated and revised on 05/28/2026. Interventions related to this focus included: educating the resident on increased moisture retention, risk for skin breakdown, and discomfort; continued assessment of the resident's preference for double diapers and discussing risks and benefits; turning and positioning every two hours; and monitoring of skin every shift. According to the AR, Resident #3 was admitted to the facility with diagnoses including but not limited to rhabdomyolysis (muscle break down, which leads to toxins from muscle fibers to enter circulatory system and can lead to kidney damage); type 2 diabetes mellitus without complications; sepsis, unspecified organism (life-threatening reaction to an infection that causes the immune system to harm healthy tissues and organs); and urinary tract infection, site not specified. The Admission/readmission Eval-IDT - V2 (ARE) for Resident #3 with an effective date of 05/27/2026 was reviewed. The ARE revealed that Resident #3 was incontinent of bowel and bladder and used IBs for protection. The ARE further revealed that Resident #3 was chairfast with a severely limited or non-existent ability to walk and required assistance to the chair or wheelchair. Review of the CP for Resident #3 revealed a Focus that Resident #3 had the potential for skin impairment related to the resident's fragile skin, initiated on 05/28/2026. Interventions related to this focus included but were not limited to providing incontinent care as needed and keeping skin clean and dry. Review of the CP for Resident #3 revealed a Focus that the resident had decreased activities of daily living (ADL) skills related to decreased mobility, decreased muscle strength, and decreased functional endurance, initiated on 05/28/2026. Interventions related to this focus included ADL re-training, patient and caregiver training, and discharge planning. Review of the CP for Resident #3 revealed a Focus related to Resident #3's preference for double diaper use, initiated on 05/28/2026. Interventions related to this focus included but were not limited to assessing and documenting the resident's preferences for double IBs and discussing the risks and benefits; educating the resident regarding the risk for skin breakdown, risk for infection and discomfort; and encouraging the use of one appropriately sized IB whenever possible. An interview was conducted with UM #1 on 05/28/2026 at 11:10 AM. UM #1 confirmed that Resident #2 and Resident #3 were each<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | observed wearing two IBs during incontinent rounds that morning. UM #1 further stated that some residents preferred to wear two briefs, and this should be part of the resident's CP. An interview was conducted with CNA #2 on 05/28/2026 at 2:05 PM. CNA #2 stated that Resident #3 requested to wear two IBs. CNA #2 stated that she did not make the resident's nurse aware of the resident's request. An interview was conducted with CNA #1 on 05/28/2026 at 2:15 PM. CNA #1 stated that Resident #2 asked her to put an absorbent pad in their IB, so CNA #1 removed the tape tabs from a small IB to make a pad and placed it in the resident's outer IB. CNA #1 stated that the resident's nurse was not informed that the resident was wearing two briefs and that the nurse had not authorized the use of two briefs. A follow up interview was conducted with UM #1 on 05/28/2026 at 3:53 PM. UM #1 stated that the incontinent round conducted with the surveyor did not meet her expectations for incontinence care. UM #1 stated that Resident #2 and Resident #3 had requested to wear two IBs. UM #1 stated that the CNA #1 should have discussed this with the nurse before placing two IBs on the resident. UM #1 stated that CNA #2 had not told the nurse that Resident #3 was placed in two IBs. UM #1 stated that the use of two IBs was added to Resident #2's and Resident #3's CPs that day after incontinent rounds were conducted. UM #1 further stated that wearing two IBs retained extra moisture and contributed to skin break down. An interview was conducted with the Director of Nursing (DON) on 05/28/2026 at 5:45 PM. The DON stated that facility staff were aware that placing two IBs on a resident was generally not acceptable. The DON stated that CNAs should check with the resident's nurse before placing two IBs on a resident. The DON stated that nurses and UMs would have then educated the resident about the risks of using two IBs, and updated the resident's CP. The DON stated that she updated the resident's CPs that day after IRs were conducted by the surveyor. The DON further stated that if a resident requested to wear two IBs, and nurses were aware, it should have been added to the resident's CP. The facility policy INCONTINENT CARE with an effective date of 01/09/2022 and a last reviewed date of 03/24/2026 was reviewed. Under PURPOSE the facility policy revealed To maintain resident's dignity, prevent infection and prevent skin breakdown. Under PROCEDURE the facility policy indicated that the Registered Nurse (RN) was responsible to place in PCC (Point Click Care) the tasks that the resident required for incontinent care and to place instructions related to the type and size of incontinent product to be used. The same section of the facility policy revealed that CNAs were responsible for reviewing the tasks for each resident before providing care. NJAC 8:39-27.1(a) |