STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. Building B. Wing	09/19/2024

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29728 Based on interview, record review, and facility policy review, the facility failed to notify the resident's representative of a significant change in the resident's skin condition for one of two residents (Resident (R) 224) reviewed for pressure sores out of a total sample of 37. The facility failed to provide documentation that R224's representative was notified of a pressure area on the resident's heel when she returned to the facility after a recent hospitalization . Findings include: Review of the facility's Notification of Changes policy, dated 11/2022 and 06/2023, revealed, . The facility must inform the resident, consult with the resident's physician, and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances may be . Significant change in the resident's physical, mental or psychological condition such as deterioration in health, mental or psychosocial status . Review of R224's Face Sheet, provided by the facility, revealed an initial admitted [DATE] and a readmitted [DATE] with diagnoses of atherosclerotic heart disease, cardiomyopathy, atrial fibrillation, severe aortic stenosis, congestive heart failure, peripheral vascular disease, and dementia. Review of R224's Resident Exit-Skin/Wound Assessment, located under the Miscellaneous tab of the EMR and dated 11/20/22, revealed the resident was discharged to the hospital with only one pressure area, an unstageable pressure sore on the sacrum. Review of R224's Admit/Readmit Screener form, dated 11/24/22 and completed when the resident returned to the facility, revealed the presence of one Stage III pressure area on the sacrum, one Stage III pressure area on the right lower buttock, and one unstageable pressure area on the left heel. During an interview on 09/17/23 at 1:00 PM, R224's Family Member (1) stated that she was not aware of the pressure area on the resident's left heel. Review of R224's Progress Notes and Miscellaneous tabs of the EMR revealed no documentation Family Member 1 was notified of the left heel pressure area. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the MDS/Care Plan Coordinator on 09/19/24 at 3:00 PM, she stated that they held an IDT meeting after R224 returned from the hospital on 12/02/22, and Family Member 1 was in attendance. She stated that she remembered discussing the wound on the resident's left heel with the family, but did not remember what meeting that was. After reviewing the IDT meeting notes, she confirmed that the note did not include documentation of the unstageable pressure sore on the left heel. NJAC 8:39-13.1(c)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review, interview, and policy review, the facility failed to conduct a thorough investigation of an alleged incident of staff neglect for one resident (R375) of four residents reviewed for abuse out of a total sample of 37 after the family stated the resident told them staff dropped him during a transfer, and the resident was found to have a right femur fracture. This has the potential to affect all residents receiving care by staff who may put residents at risk for neglect during care. Findings include: Review of R375's Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R375 was admitted to the facility on [DATE]. R375, who required staff assistance for transfers, was transferred by staff at various times on the morning of 04/17/23 prior to a podiatrist appointment at 1:00 PM. After R375 returned from the appointment, he complained of pain in his right leg and was sent to the hospital for further evaluation. Xrays revealed a right femur fracture, and R375 was admitted to the hospital. On 04/20/23 family members reported to the facility that R375 told them he fell and hurt his leg during a transfer by staff before leaving for his 1:00 pm appointment on 04/17/23. Review of the Facility's Investigation, dated 04/20/23, revealed that there were no interviews with the physical therapy aides or other staff that assisted with transfers on the morning of 04/17/23 before he was transferred to his wheelchair to go to his appointment at 1 PM. The staff that assisted with these transfers were not identified. Staff only identified, interviewed, and obtained statements from the two certified nurse aides that assisted with the transfer prior to the resident leaving for his 1:00 PM appointment. Review of R375's Discharge Minimum Data Set (MDS) with an assessment reference date (ARD) of 05/05/23 revealed a Brief Interview for Mental Status (BIMS) score was not determined. During an interview on 09/19/24 at 11:56 AM, the Administrator stated the former Director of Nursing (DON) completed the investigation but that she now works for the state now. She said she contacted her and was told she would need to talk with her supervisor before answering any questions. The Administrator stated she felt like the fracture for R375 was likely the result of the braces the resident wore due to the weight, and she felt they did a thorough investigation. She stated she was unaware that all staff involved with transfers on the morning of 04/17/23 were not identified or interviewed. The Administrator confirmed all staff that assisted with any transfers on 04/17/23 should have been interviewed. She said she was going to have to reread the investigation. NJAC 8:39-9.4(f)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902 Based on record review and staff interview, the facility failed to ensure that a Preadmission Screening and Resident Review (PASARR) Level I Assessment was completed accurately for two of three sampled residents (Resident (R) 108 and R79) reviewed for PASARRs out of a total sample of 45 residents. This had the potential to prevent or delay additional services to a resident that might qualify for a Level II PASARR. Findings include: 1. Review of R108's Admission Record, located in the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including major depressive disorder, generalized anxiety disorder, and hallucinations. Review of R108's quarterly Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 08/07/24, revealed she scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated R108 had no cognitive impairment. Further review revealed R108 had active diagnoses of major depressive disorder and anxiety disorder. Review of R108's Level One Nursing Facility Preadmission Screening for Mental Illness, Intellectual Disability, or Related Condition (PASARR), located under the Resident Documents tab in the EMR and dated and submitted on 08/02/23, indicated no mental illness diagnosis and was marked negative for a Level II assessment. During an interview on 09/19/24 at 10:42 AM, the Social Services Director (SSD) stated after a resident was admitted to the facility, they ensured the PASARR was completed. She stated they did not admit a resident without a PASARR. The SSD stated she was the one who was responsible for reviewing the PASARRs to make sure they were completed accurately. She stated a former employee was the person who completed R108's PASARR level I but agreed it should have been completed accurately. The SSD stated she would review the R108's PASARR and have it corrected. During an interview on 09/19/24 at 11:56 AM, the Administrator stated staff should be reviewing the PASARR Level I and making sure it was correct and if it was not correct, staff needed to revise and correct it. 22411 2. Review of R79's Profile tab of the EMR revealed R79 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, recurrent and unspecified, and schizoaffective disorder, unspecified. Review of R79's quarterly MDS, located under the MDS tab of the EMR and with an ARD of 06/11/24, revealed R79 had a BIMS score of 11 out of 15, which indicated R79 was moderately cognitively impaired. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R79's PASRR (Level 1 Screen), dated 05/13/23 and located under the Misc tab of the EMR, indicated a negative screening. Further review of the PASRR revealed that in Section II, there was no response to the question related to mental illness. It was recorded R79 had not been hospitalized related to mental illness within the last 2 years. Review of R79's psychiatry Progress Notes, dated 12/21/23 and located under the Misc tab of the EMR, revealed R79 was seen by the psychiatric group for schizophrenia and depression. The progress note revealed, . resident with a history of Depression . Patient has a history of inpatient hospitalization s at [hospital name withheld] 2 years ago for depression . During an interview on 09/17/24 at 4:00 PM, the SSD stated that residents come from the hospital or another facility with their PASARRs already completed. When asked to review R79's PASARR, the SSD acknowledged the PASARR was not complete. The SSD stated, Unfortunately, the questions were not answered, so it is not a complete PASARR. During an interview on 09/19/24 at 10:43 AM, the SSD stated that no one had reviewed R79's PASARR. She stated it was the facility's responsibility to review the PASARRs to make sure they were correct. She stated, [R79] should have had another PASARR completed. During an interview on 09/19/24 at 3:00 PM, the Psychiatric Doctor (PD) stated R79 had been in an in-patient psychiatric facility, but he was unsure of the specific dates. NJAC 8:39-5.1(a)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30347 Based on interview, record review, and facility policy review, the facility failed to provide food that accommodated resident allergies for one of seven sampled residents (Resident (R) 81) reviewed for food concerns out of a total sample of 37. This failure had the potential to cause residents harm due to allergic reactions. Findings include: Review of R81's undated Admission Record, located in R81's electronic medical record (EMR) under the profile tab, showed a facility admitted [DATE] and a re-admitted [DATE] with medical diagnoses that included cerebrovascular disease, hemiplegia and hemiparesis, major depressive disorder. Review of R81's Food Preferences, dated 05/14/24 revealed, Dislikes fish. The form did not provide an entry for any type of food allergies. Review of R81's Care Plan dated 05/14/24 reveals, R81 has an allergy related to fish and powder eggs. Review of R81's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/16/24, revealed the facility assessed R81 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R81 was cognitively intact. During an interview on 09/16/24 at 10:36 AM, R81 stated, Last Friday [09/13/24] I was given fish for lunch. My meal ticket has that I am allergic to fish written on it. During an interview on 09/19/24 at 5:00 PM, the Assistant Director of Nursing (ADON) stated R81 had been served fish for lunch, and he ate some of it. The ADON stated he was provided Benadryl and had no signs or symptoms of an allergic reaction but requested to go to the hospital. The ADON stated R81 was sent to the hospital as requested and later took prednisone (a steroid medication that can be used to treat allergic reactions). During an interview on 09/19/24 at 5:15 PM, Registered Nurse (RN) 1 stated, [R81] informed me about fish on his lunch tray. I checked the tray, and he had been served fish and he had eaten some of it. I informed the NP [Nurse Practitioner] of the situation. The NP approved Benadryl for the resident. [R81] requested to go to the hospital. He had some redness on his face and was given prednisone before going to the hospital. During an interview on 09/19/24 at 5:20 PM, the Dietary Manager (DM) stated, When I went to check his lunch tray, [R81] had been served fish by accident. His meal ticket identified a food allergy to fish. The DM stated R81 refused to return the tray and was later observed in the smoking area scratching at his face. The DM stated, Since the incident, his meal ticket has been modified to verify the meal prior to serving. The meal ticket system automatically changes the meal due to allergy and dislikes. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/19/24 at 5:45 PM, the Assistant Dietary Manager (ADM) stated, We do not have a policy and procedure related to the accuracy of the plating of food and ensuring that the resident gets the proper meal. On 09/19/24 at 6:05 PM, a review of R81's meal ticket, dated 09/13/24, with the DM for the noon meal revealed R81 was allergic to fish, and he should have been given the alternate meal consisting of stuffed shells, tomato sauce, mixed vegetables, dinner roll, ice cream, apple juice, whole milk, ginger ale, coffee, and a small, tossed salad. The DM confirmed, The meal ticket system worked as indicated by the alternate meal being identified. However, [R81] was served the incorrect meal. NJAC 8:39-17.4(c)(e)