

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Optima Care Castle Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 615 23rd St Union City, NJ 07087	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490</p> <p>Based on observation, record review, interview, and review of the facility policies, the facility failed to ensure staff followed enhanced barrier precautions (EBP) and standard nursing precautions while transferring one of nine residents (Resident (R)1) reviewed on EBP. Specifically, facility staff failed to don personal protective equipment (PPE) (gown and gloves) when transferring R1 from his/her bed to his wheelchair. Additionally, two Certified Nurse Aides (CNAs) and one Licensed Practical Nurse (LPN) did not follow hand washing protocol during the lunch meal services.</p> <p>Findings include:</p> <p>Review of R1's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed R1 was originally admitted to the facility on [DATE] with diagnoses including end stage renal disease.</p> <p>Review of R1's Physicians Order, located in the EMR under the Orders tab, dated 03/29/24 revealed, .on Enhanced Barrier Precautions [EBP] .</p> <p>During an observation on 02/02/25 at 11:55 PM on the COVID unit, EBP signage was posted at the entrance of R1's room. During this time, CNA2 entered R1's room carrying a meal tray, placed the tray on his bedside table, and preceded to transfer R1 from his bed to his wheelchair. CNA2 was not wearing PPE during the transfer.</p> <p>During an observation on 02/10/25 at 12:22 PM on the COVID unit, CNA3 removed a dirty meal tray from the dining room, placed the dirty tray in a food cart, and proceeded to another resident room to provide care. CNA3 did not use alcohol-based hand rub (ABHR) in between rooms/residents. During this same observation, CNA1 removed a dirty meal tray from the dining room, placed the dirty tray on the food cart, returned to the dining room, and assisted residents in the dining room. CNA1 did not use ABHR or wash her hands between tasks.</p> <p>During an interview on 02/10/25 at 12:19 PM, CNA2 confirmed she did not follow proper donning (process of putting on protective gear to protect you from infection) while transferring R1. CNA 2 confirmed she should have worn a gown and gloves.</p> <p>During an interview on 02/10/25 at 12:41 PM, CNA1 confirmed she did not follow the proper hand hygiene protocol while handling dirty meal trays and should have used ABHR between residents/tasks.</p> <p>(continued on next page)</p>

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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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/10/25 at 12:47 PM, Licensed Practical Nurse (LPN)1 revealed that she, along with CNA1 and CNA3, did not follow the proper hand hygiene protocol. LPN1 continued to share that staff should have sanitized their hands by using ABHR before returning to the dining room area and in between residents to prevent the spread of infections.</p> <p>During an interview on 02/10/25 at 12:56 PM, the facility Infection Preventionist (IP) revealed staff should wash or sanitize their hands with ABHR between each resident when providing care or removing dirty meal trays. The IP continued to share this is her expectation of her staff to follow proper PPE and hand hygiene protocols.</p> <p>During an interview on 02/10/25 at 1:03 PM, the Director of Nursing (DON) revealed all staff were expected and should know to don a gown and gloves before entering an EBP room to provide care. The DON continued to share staff should wash or sanitize their hands between each resident.</p> <p>Review of the facility's policy titled, Enhanced Barrier Precautions, revised date August 2024 revealed, Enhanced Barrier Precautions (EBP) are an infection control intervention used to reduce transmission of multidrug-resistant organisms . EBP is an extension of standard precautions utilized for residents . all staff must wear gloves and gown during high contact activities for residents . transferring .</p> <p>Review of the facility policy titled, Hand Hygiene dated July 2023, revealed, . It is the policy of this facility to ensure that facility staff performs proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .</p>