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	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optima Care Fountains	595 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review and policy review, it was determined that the facility failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 2/12/26 at 10:30 AM, in the presence of the Food Services Director (FSD) and the Kitchen Supervisor (KS), the surveyor observed the following: In the south kitchen food preparation area, the surveyor observed that 1 of 2 of the fire suppression poles and sprinkler heads were soiled with a grease-like substance and dust like particles. In the food preparation area, the surveyor observed 3 of 10 burners on the cook top, which were soiled with a thick black grease-like substance, which was easily lifted with the tip of the surveyor's pen.In the food preparation, the surveyor observed the ice machine's internal plastic barrier, which was soiled with black and brown colored particles. The KS stated that the barrier was soiled and should have been cleaned.The surveyor observed the north kitchen dry storage with the FSD and the assistance (AFSD). In the food preparation area, the surveyor observed that stove number one had 4 of 6 burners on the cook top soiled with a thick black grease-like substance, which was easily lifted with the tip of the surveyor's pen. Adjacent to stove number one, in the food preparation area, the surveyor observed stove number two, which had 2 of 6 burners on the cook top soiled with a thick black grease-like substance, which was easily lifted with the tip of the surveyor's pen. A review of the Ice policy and procedure revised on 9/2025, revealed that the FSD will coordinate with maintenance to ensure that the ice machine is cleaned and sanitized quarterly and as needed. A review of the Oven and Range Cleaning policy revised on 9/2025, revealed that all ovens and stove top ranges will be properly cleaned by cook after each meal service, all ovens and stove tops will be cleaned once a week with a grease cutting commercial cleaning chemical, and any excess build up will be scraped off and then cleaned using a scouring pad. 02/18/2026 02:19 PM discussed above concerns with the LNHA and DON02/19/2026 10:40 AM DON and LNHA stated that they will be changing procedures to ensure that the kitchen environment will be maintained in a clean manner. On 2/18/26 at 2:19 PM, the surveyor reviewed the above concerns with the Administrator and the Director of Nursing (DON). On 2/19/26 at 10:40 AM, the Administrator and DON stated that they will be changing procedures to ensure that the kitchen environment will be maintained in a clean manner. NJAC 8:39-17.2(g)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure call lights were within residents' reach and easily accessible for 4 of 33 residents reviewed (#15, #19, #57 and #234) and was evidenced by the following.This deficient practice was evidenced by the following: 1.On 2/12/26 at 10:29 AM, the surveyor observed Resident #57, in a bed that was low to the floor and against the wall. The call light was inaccessible to the resident as it extended between the wall and the bed, resting on the floor under the bed. On 2/12/26 at 12:10 PM, the surveyor returned to the resident's room. The call bell remained inaccessible in the same location as the previous observation. The surveyor confirmed the call light's placement with the Certified Nursing Assistant (CNA) #1. She stated the call light should be accessible to the resident. On 2/12/26 at 12:20 PM, the surveyor spoke with the Unit 11 Registered Nurse Unit Manager. The nurse confirmed the call light should be accessible to the resident when in bed. A review of the resident's electronic medical revealed the following information. The admission record (AR) listed diagnoses including but not limited to: dementia with behavioral disturbance; mood disorder; and alcohol abuse. A review of the 2/21/25 significant change Minimum Data Set (MDS) assessment tool indicated the resident required maximum assistance with all activities of daily living. A review of the 11/19/25 quarterly MDS indicated the resident had no cognitive deficits (brief interview of mental status - BIMS - score of 15). A review of the fall care plan identified that the resident was at risk for falls and had sustained a fall in their room on 5/5/25. 2. On 2/12/26 at 11:00 AM, the surveyor observed Resident #15 asleep in bed. The surveyor observed that the resident's call device was on the floor, located all the way at the foot of the bed. On 2/13/26 at 11:28 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #15, which revealed the following: A review of the admission Record (AR, an admission summary) reflected Resident #15 was admitted with diagnoses that included but were not limited to; an unspecified dementia (loss of memory), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (excessive worry). A review of the significant change Minimum Data Set (SC/MDS), (an assessment tool used to facilitate the management of care) dated 1/19/26, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the resident had severe cognitive impairment. Further review of the SC/MDS, as reflected in section GG, revealed that Resident #15 is dependent on staff for activities of daily living (ADL). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Care Plan (CP) report initiated on 2/6/26 focused on the residents' risk for falls related to impaired balance, use of psychotropic medications, and right eye blindness. Interventions included, but were not limited to, ensuring the call light is within reach and encouraging the use of it as needed for assistance. 3. On 2/12/26 at 11:15 AM, the surveyor observed Resident #19 sitting on the bed watching television. Resident #19 was alert and oriented, able to answer the surveyor's inquiry. The surveyor observed that the resident's call device was at the back of the bed, and the resident was unable to reach it due to the contraction of both hands. The resident stated that they never used the call device because the staff would not answer it anyway. On 2/13/26 at 10:51 AM, the surveyor reviewed the hybrid medical record of Resident #19, which revealed the following: A review of the AR reflected that Resident #19 was admitted with diagnoses that included but were not limited to; schizophrenia (a mental disorder that affects how the person thinks, feels, and behaves). A review of the quarterly MDS (Q/MDS) dated [DATE] indicated that the facility assessed the residents' cognitive status using a BIMS score of 15 out of 15, which indicated that the resident had intact cognition. Further review of the Q/MDS, as reflected in section GG, revealed that Resident #19 requires assistance from the staff for ADLs. A review of the CP report initiated on 4/24/24 focused on the residents' risk for falls. Interventions included, but were not limited to, ensuring the call light is within reach and encouraging the use of it as needed for assistance. 4. On 2/12/26 at 11:18 AM, the surveyor observed Resident #234 in bed, awake, and able to answer the surveyor's inquiry. The surveyor observed that the resident's call device was on the floor, located at the foot of the bed. Resident #234 stated that they had been calling for help for almost an hour because they needed their adult brief changed. Resident #234 mentioned that they did not know where the call device was and that they scream for help instead. The roommate assisted them in calling for help, as they sometimes cannot be heard. On 2/13/26 at 9:43 AM, the surveyor reviewed the hybrid medical record of Resident #234, which revealed the following: A review of the AR reflected that Resident #234 was admitted with diagnoses that included but were not limited to; cerebrovascular (a condition that affects blood flow to the brain) disease and unspecified cataract (the lens of the eye becomes cloudy). A review of the annual MDS (A/MDS) dated [DATE] indicated that the facility assessed the residents' cognitive status using a BIMS score of 10 out of 15, which indicated that the residents had moderately impaired cognition. Further review of the A/MDS, as reflected in section GG, revealed that Resident #234 is dependent on staff assistance for ADLs. A review of the CP report initiated on 12/24/25 focused on the residents' risk for falls related to a history of falls. Interventions included, but were not limited to, ensuring the call light is within reach and encouraging its use as needed for assistance. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/26 at 11:19 AM, the surveyor interviewed the Certified Nurse Assistant (CNA), who stated that she was attending to another resident and would attend to Resident #234 as soon as she finished. The CNA added that the call bell should always be within the resident's reach. On 2/12/26 at 11:20 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated that the call device of the residents should be near them so that if they needed help, they could call the staff. On 2/18/26 at 2:18 PM, the team of surveyors met with the Licensed Nursing Home Administrator, Director of Nursing, and the Regional Clinical Director regarding the above concern. There is no information provided. A review of the facility policy titled Call lights: Accessibility and Timely Response, revised on 7/25, revealed under Procedure 4. Staff will ensure the call light is within reach of the resident and secured, as needed. 9. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. NJAC 8:39-31.8(c)(9)

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. Based on interview and review of facility documents, it was determined that the facility failed to ensure that residents who maintained a Personal Needs Account (PNA) received a written notification that their account approached the limit that could jeopardize a resident's eligibility for Medicaid. This deficient practice was identified for 7 of 212 residents (Resident #4, #62, # 97, #183, #214, # 274, and #280) who maintained a PNA at the facility and was evidenced by: On 2/12/2026 at 11:08 AM, during entrance conference with the License Nursing Home Administrator (LNHA), the surveyor requested a list of the PNA balances.A review of the Fund Balances Report (FBR) from 2/11/2026 revealed a list of 212 active resident names with a total balance of $139,435.20. There were seven (7) residents listed with PNA funds that range from $1990.48 to $7956.76. On 2/18/2026 at 10:37 AM, the surveyor interviewed the Business Office manager (BOM), who stated [name redacted-the business management office (BMO)] manages resident's PNA balances. She stated the BMO would send her an email informing her the resident was approaching $2000. The BOM stated she would work with the social worker to reach out to the resident or resident representative to spend down the resident's money by purchasing clothes or making a bigger purchase. The BOM reviewed the provided FBR in the presence of the surveyor and acknowledged the balances nearing $2000 or exceeding it. The surveyor asked the BOM to provide any written notification that the facility attempted to make the above mentioned residents or their resident representatives aware their account balance was over $1800. On 2/19/2026 at 9:25 AM, the BOM provided the surveyor with the following:-An invoice for Resident #4 dated 2/18/2026 (after surveyor inquiry) to be billed to the residents PNA.-An invoice for Resident #62 dated 2/18/2026 (after surveyor inquiry) to be billed to the residents PNA.-An email that Resident #97's resident representative was contacted to spend down their PNA, dated 1/22/2026. No additional information was provided until after surveyor inquiry which was an invoice for Resident #97 dated 2/18/2026 to be billed to the residents PNA.-An email dated 2/18/2026 (after surveyor inquiry) from the facility's Social Services that Resident #183's guardian was contacted to spend down their money Per state guidelines, we are required to assist with spending down the balance. -An invoice for Resident #274 dated 2/18/2026 (after surveyor inquiry) to be billed to the residents PNA.No additional information was provided for Residents #214 and #280.At that time the BOM stated it was important to spend down the PNA because a higher balance could have the resident disqualified from their Medicaid benefits.On 2/19/2026 at 10:51 AM, the surveyor interviewed the LNHA, who stated he was aware of the surveyors concerns with the PNA balances. He stated the BOM should notify the residents when they were getting close to hitting the cap of $2000, to make sure they did not lose their Medicaid Benefits. The surveyor made the LNHA aware that the spend down invoices that were provided were dated after surveyor inquiry. The LNHA was also made aware no information was provided for Resident #214 and #280.A review of the facility policy Personal Needs Allowance, revised 11/2022 revealed Policy: To ensure that each resident who receives Medicaid benefits is provided access to their Person Needs Allowance (PNA) in accordance with federal and New Jersey State regulations, and that resident funds are safeguarded, accurately accounted for, and made available upon request .7. Medicaid Resources Limits: The business Office will monitor resident account balances to ensure compliance with Medicaid resource limits. Residents and/or representatives will be notified if funds approach the Medicaid resource threshold. Documentation of notifications will be maintained.NJAC 8:39-9.5(c)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review it was determined that the facility failed to provide resident confidentiality for 2 residents (#57, #225) of 33 reviewed for confidentiality and privacy and was evidenced by the following.1.On 2/12/26 at 10:16 AM, the surveyor observed Resident #57 in a low bed with eyes closed. The surveyor observed a handwritten sign taped to the front of the resident's clothes closet. The sign included care instructions for staff.A review of the electronic medical record revealed the following information.A review of the 11/19/25 quarterly Minimum Data Set (MDS) assessment tool indicated the resident had no cognitive deficits as evidenced by a Brief Interview for Mental Status (BIMS) score of 15. The resident had diagnoses including but not limited to dementia with behavioral disturbance and mood disorder.On 2/18/2026 at 10:16 AM, the surveyor interviewed the Unit 11 Registered Nurse Unit Manager. She was not aware of the signage and stated she would place the sign inside the resident's closet. 2. On 2/12/26 at 11:26 AM, the surveyor observed Resident #225, awake and alert and seated on the side of the bed.The surveyor observed a handwritten sign in Spanish taped to the wall above the resident's bed. The Certified Nursing Assistant stated the sign referred to the resident's behavior of placing pieces of paper in the air conditioning unit and on the windowsill. The sign instructed housekeeping staff to discard the papers when cleaning the room. A review of the electronic medical record revealed the following information. A review of the 1/25/26 quarterly MDS indicated the resident had no cognitive deficits as evidenced by a BIMS score of 13. The resident had diagnoses including but not limited to schizophrenia, dementia, and anxiety. On 2/18/26 at 10:18 AM, the surveyor interviewed the Unit 11 Registered Nurse Unit Manager. She stated she did not know the sign was there. She stated she was going to move it to the housekeepers closet. On 2/18/26 at 2:19 PM, the surveyor discussed the privacy concerns with the Administrator, Director of Nursing (DON), and the Regional Clinical Nurse. On 2/19/26 at 11:00 AM, the DON stated employees were educated not to post personal resident information in resident rooms. She further stated the information was moved to inside the resident's closet. A review of the facility policy Promoting/Maintaining Resident Dignity, revised 10/2024, instructs staff to maintain resident privacy. NJAC 8:39-4.1(a)18.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and review of facility documents, it was determined that the facility failed to maintain a clean/homelike and sanitary environment for the residents. This deficient practice was identified on 4 of 7 nursing units and was evidenced by the following:1. On 2/12/2026 beginning at 10:00 AM, the surveyor toured the first and second floors of Unit 11. The following environmental concerns were observed: -The first-floor day room/dining room had 2 chairs with torn vinyl on the seats. The wall-mounted air-conditioning unit had a broken face panel exposing the underlying coils. -The first-floor shower room's baseboard heating element was rusted and had chipped paint. The windowsill was damaged, and the window was not closed completely with a towel placed between the sill and the bottom of the window. On the sink top were open bottles of body wash, shampoo, and shaving cream, and an open brick pack of Glucerna nutritional drink. In the sink drain was a container of deodorant. The shower stall walls and ceiling had blackish discolorations. -The bathroom of room [ROOM NUMBER] had a hole in the wall behind the toilet. The cove base molding below the paper towel dispenser was broken and pulled away from the wall. The baseboard heating element had exposed yellow and black insulation exposed from under the unit. The floor had blackish discoloration. -The bathroom of room [ROOM NUMBER] had a baseboard heating element with exposed broken fins. The cove base molding near the door to the hallway was cracked and pulled away from the wall. The resident's wheelchair seat cushion was soiled with food debris. -The entirety of the second-floor hallways was missing cove base molding exposing cracked and missing wall board at the junction of the wall and floor. -Loose and broken floor tiles were observed outside room [ROOM NUMBER]. -End caps were missing from the handrails near rooms 2107, 2108, 2109, 2110, 2111, 2112, 2114, near the second floor public phone, and near the second floor shower. On 2/17/2026 at 10:25 AM, the surveyor interviewed the Unit 11 Registered Nurse Unit Manager and confirmed the areas of disrepair on Unit 11. She stated the maintenance department does do rounds. She showed the surveyor the maintenance logbook (MLB). The surveyor noted not all concerns were signed off as fixed or completed going back to 9/2025. On 2/18/2026 at 2:19 PM, the survey team discussed the environmental concerns with the Administrator and the Director of Nursing. On 2/19/2026 at 10:25 AM, the facility responded stating all cove base moldings will be replaced, handrails will be fixed, and broken floor tiles will be replaced. 2.On 2/13/2026 at 10:19 AM, the surveyor toured unit 8, 2nd floor and observed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-outside room [ROOM NUMBER] the handrail did not have an end cap -outside room [ROOM NUMBER], the handrail did not have an end cap -outside room [ROOM NUMBER], the handrail did not have an end cap -near the Emergency exit, the handrail did not have an end cap On 2/13/2026 10:24 AM, the surveyor interviewed the Certified Nursing Aide (CNA) on the unit, who stated if something was broken, she would report it to the nurse, who would then notify maintenance. She stated she was unaware of the handrails missing the end cap. On 2/13/2026 at 10:32 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1, who was at the nurse's station for unit 8. The surveyor observed a large gray patch area at the nurse's station. LPN #1 stated if something was broken, he would call maintenance and enter it into the MLB. LPN #1 provided the surveyor with the MLB. A review of the MLB from October to present did not reveal an entry for the missing end caps or the wall patch. On 2/13/2026 at 11:42 AM, the surveyor interviewed the Director of Maintenance (DOM), who stated he tried to do environment rounds monthly which included things like check call bells, furniture, walls, and lights. He stated he did morning rounds to check water temperatures and to review the maintenance books. At that time, the DOM stated he was very shorthanded. I am aware alot of things need to be fixed, we are working on it. He stated he was aware of the handrails missing the end caps. The DOM stated they do not make those particular handrails anymore, so the facility was going to replace them. He acknowledged the spackled wall at the nurse's station and stated he was going to change the whole wall color to a color that was easier to repair. On 2/18/2026 at 2:18 PM, in the presence of the survey team, the surveyor made the Licensed Nursing Home Administrator, the Director of Nursing and the Regional Clinical Director aware of the above concerns. 3. On 2/18/2026 at 11:44 AM, the surveyor and unit 9 Registered Nurse/ Unit manager (RN/UM), entered room [ROOM NUMBER] and observed a blue chair with multiple tears in it, near bed A. Bed B's bedside table was observed with multiple separations to the outside trim of the outer edge of the table. She acknowledged that the furniture should not be like that due to residents' safety. Both the RN/UM and the surveyor entered the residents' bathroom and noted a very strong odor. The RN/UM stated it smelt like urine, but she did not know where it was coming from. She stated she would call housekeeping. The residents were not in the room at the time of the observations. On 2/18/2026 at 2:18 PM, in the presence of the survey team, the surveyor made the Licensed Nursing Home Administrator, the Director of Nursing and the Regional Clinical Director aware of the above concerns. 4. On 2/12/26 at 12:22 PM, during the first day of the survey, the surveyor, together with the Licensed Practical Nurse/ Unit Manager (LPN/UM), observed the unit 12 first floor, where there was a square hole in the wall under the call light system in between the 2 residents' beds in room [ROOM NUMBER]. The LPN/UM did not provide further information regarding the above concern. On 2/18/26 at 2:18 PM, the team of surveyors met with the Licensed Nursing Home Administrator, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing, and the Regional Clinical Director regarding the above concern. There is no information provided. 5. On 2/18/2026 at 10:10 AM, in room [ROOM NUMBER]-A located on the 1st floor on the ninth unit, the surveyors observed a missing top drawer on the nightstand in the presence of the Registered Nurse/Unit Manager (RN/UM). The surveyor asked the RN/UM what happened, and she stated that the resident broke the drawer a few days ago. When the surveyor asked the RN/UM about the process for reporting concerns to the maintenance department, she stated that the process was to document concerns in the maintenance logbook or report it verbally. The surveyor asked the RN/UM if she reported the missing drawer to the maintenance department, and she stated she did not report it. When the surveyor asked if it was okay for there to be no drawer, she stated no, and that it does not look homelike. On 2/18/2026 at 10:25 AM, the surveyor interviewed the DOM, who stated the process of reporting concerns was through documentation in the Maintenance Logbook, text, and phone call. The DOM stated that he was unaware of the missing top drawer on the nightstand. When the survey asked if there should be a missing top drawer, the DOM stated no. A review of the MLB on 02/18/2026 at 10:15 AM, indicated no documentation of a request to address the top missing drawer on the nightstand in room [ROOM NUMBER]-A. On 2/18/2026 at 2:18 PM, in the presence of the survey team, the surveyor made the Licensed Nursing Home Administrator, the Director of Nursing and the Regional Clinical Director aware of the above concerns. 6. On 2/18/2026 at 10:22 AM, on unit 9 hallway wall across from the nursing station, which was to the left after exiting the elevator, the surveyors observed the vinyl coping along the floor separated and protruding from the wall. When the surveyor asked the RN/UM, she stated that she was unaware. When the surveyor asked the RN/UM the impact, the UM stated that a resident could trip on it. A review of the revised dated 10/2024 policy titled Resident Environment under Policy indicated, It is the policy of this facility to provide a safe, clean, comfortable and homelike environment, allowing the residents to use their belongings to the extent possible. Under Procedure, 1). Ensure that residents can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. NJAC 8:39-31.4(a-f)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, review of the facility's policy, and other pertinent facility documents, it was determined that the facility failed to implement their abuse policy to complete background checks for 3 out 97 employees (Employee #1, #2, #3). This deficient was identified for newly hired employees reviewed since last survey from 10/17/2024 and was evidenced as follows:A review of the employee personnel files revealed the following:For Employee #1, a dietary staff (cook) with a start date of 6/16/25, there was no evidence of a background check prior to the start of employment.For Employee #2, a Certified Nursing Assistant (CNA) with a start date of 4/1/25, there was no evidence of a background check prior to the start of employment. For Employee #3, a Certified Nursing Assistant (CNA) with a start date of 4/23/25, there was no evidence of a background check prior to the start of employment. On 2/19/26 at 11:16 AM, the surveyor interviewed the Business Office Manager, who stated that background checks should be completed prior to the employees' hire. She further stated that it would be completed prior to the employees' first day of orientation and that she was the one responsible for completing the background checks. She stated that if an employee resigned and then was rehired, they were required to have a background completed again before their first day of work. She also stated that the importance of completing a background check prior to hire was to ensure they don't have any prior convictions. On 2/19/26 at 10:25 AM, in the presence of the survey team, the surveyor made the Licensed Nursing Home Administrator (LNHA), Regional Clinical Director (RCD), and Director of Nursing (DON) aware of the concerns regarding employee background checks prior to hire. The LNHA acknowledged that the background checks should be completed prior to hire in accordance with their abuse policy. The LNHA further acknowledged that background checks should be completed for any employee that was a rehire. The facility could not provide any additional background checks for the three employees listed above. A review of the facility's Abuse, Neglect and Exploitation policy, revised 7/2023.potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. Background, reference, and credentials check shall be conducted on potential employees, contracted temporary staff, students affiliated with academic institutions, volunteers, and consultants.the facility will maintain documentation of proof that the screening occurred. A review of the facility's Personal Needs Allowance policy, revised 11/2022. The facility shall conduct comprehensive pre-employment screening and background checks in accordance with federal regulations and New Jersey law prior to allowing any individual to have direct or indirect access to residents. No individual shall be permitted to begin employment until all required background clearances are obtained or conditional employment requirements under New Jersey law are satisfied.Criminal Background Checks (New Jersey Requirements) .prior to hire (or conditional hire as permitted by NJ law), the facility will complete criminal history record background check. Review of convictions pursuant to NJ long-term care disqualification statutes. NJAC 8:39-9.3(b)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optima Care Fountains	595 County Avenue Secaucus, NJ 07094

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on the interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS, an assessment tool used to facilitate the management of care) in accordance with federal guidelines. This deficient practice was identified for 1 of 1 resident (Resident #25) during the review of resident assessment. This deficient practice was evidenced by the following: The MDS is a comprehensive tool, a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of completing the assessment. After the MDS is transmitted, a quality measure will be transmitted to enable a facility to monitor the residents' decline or progress. On 2/18/26 at 10:57 AM, the surveyor provided the MDS Coordinator/Registered Nurse (MDSC/RN#1) with Resident #25 who had completed a quarterly MDS (Q/MDS) assessment. The surveyor also requested a copy of the resident's final validation report (generated after every MDS transmission) from the Centers for Medicare and Medicaid Services (CMS). On the same date at 11:10 AM, the surveyor interviewed the MDSC/RN#1, who provided the surveyor with the final validation of the late MDS submission for Resident #25's Q/MDS assessment which had an ARD of 12/14/25. It was signed as completed on 12/28/25 and not transmitted until 2/5/26. MDSC/RN#1 stated that she was the one who did the assessment, and she would make sure that the MDS assessment would be export-ready so that the MDSC/RN #2 knew that it was ready for submission. On 2/18/2026 at 11:20 AM, the surveyor interviewed the MDSC/RN#2, who confirmed that he did all the MDS submissions. The MDSC/RN stated that if the MDS assessment was not signed or completed on time, and it was not locked, he could not submit it. On 2/18/26 at 2:18 PM, the team of surveyors met with the Licensed Nursing Home Administrator, Director of Nursing, and the Regional Clinical Director regarding the concern above. The facility did not provide further information. The facility policy titled Resident Assessment Policy, with a revised date of 10/24, revealed under Procedure:10. All resident assessments will be transmitted by the MDS Coordinator/designee in accordance with Centers for Medicare and Medicaid Services guidelines. NJAC 8:39-11.1

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to accurately code the Minimum Data Set (MDS, an assessment tool used to facilitate the management of care), in accordance with federal guidelines, for 1 (one) of 36 residents (Resident #15), who were reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: On 2/12/26 at 11:00 AM, the surveyor observed Resident #15 asleep in bed. On 2/13/26 at 11:28 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #15, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #15 was admitted with diagnoses that included but were not limited to; an unspecified dementia (loss of memory), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (excessive worry). A review of the significant change Minimum Data Set (SC/MDS) dated [DATE], indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 0 out of 15, which indicated that the resident had severe cognition. Further review of the SC/MDS, as reflected in section O - Special Treatments, Procedures and Program Hospice (specialized care focused on comfort, dignity, and quality of life for people nearing the end of life) Care while resident - No. A review of the Care Plan (CP) report initiated on 1/5/26 focused of DNR (Do Not Resuscitate), DNI (Do Not Intubate), and Hospice. A review of the facility form titled Communication/Continuation Note with a written date of 1/6/26 as the initial visit revealed a handwritten primary diagnosis of senile degeneration of the brain (a brain disorder that slowly destroys memory and thinking skills). On 2/18/26 at 12:30 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who confirmed that Resident #15 was in [Name Redacted] Hospice but could not tell the exact date the resident was admitted to hospice care. On 2/18/26 at 12:40 PM, the surveyor called the [Name Redacted] Hospice, and the office manager confirmed that Resident #15 was admitted to hospice on 1/6/26. On 2/18/26 at 1:16 PM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who revealed that they did the SC/MDS due to admission in hospice of Resident #15 in January. The MDSC/RN stated that it was an error that the hospice was not triggered, and they will correct the error. On 2/18/26 at 2;18 PM, the team of surveyors met with the Licensed Nursing Home Administrator, Director of Nursing, and the Regional Clinical Director regarding the concern above. The facility did not provide further information. The facility policy titled Resident Assessment Policy, with a revised date of 10/24, revealed under Procedure: 8. All persons who have completed any portion of the MDS Resident Assessment Form must sign the document attesting to the accuracy of such information. NJAC 8:39-33.2 (d)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that a residents who were unable to carry out activities of daily living (ADL) were provided care consistent with their needs and preferences for 2 of 3 residents (Resident #234 and #252) reviewed for ADL care.This deficient practice was evidenced by the following: 1. On 2/12/26 at 11:11 AM, the surveyor observed Resident #252 lying in their bed. Resident #252 was alert, verbally responsive, and Spanish speaking. The surveyor observed the resident's fingernails on both hands were long. The surveyor in Spanish asked the resident about their nail care. Resident #252 stated that their nails had not been trimmed, and they liked their nails kept short. On 2/12/26 at 2:28 PM, the surveyor reviewed the Electronic Medical Record (EMR) of Resident #252. The admission Record (a summary of important information about a resident) revealed Resident #252 had a diagnosis which included but was not limited to; hemiplegia (weakness on one side of the body) and hemiparesis (paralysis on one side of the body) following cerebral infarction (stroke). A review of the Quarterly Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, with an Assessment Reference Date (ARD) of 12/22/25 indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #252 scored 14 out of 15, which indicated the resident was cognitively intact. The resident was coded in the MDS as requiring substantial/maximum assistance with personal hygiene care. A review of the resident's care plan included a focus area of ADL care. The care plan did not address Resident #252's nail care. There was no documentation to indicate the resident refused care. A review of February 2026 progress notes revealed no documentation of the resident refusing nail care. On 2/13/26 at 10:38 AM, the surveyor interviewed the Certified Nurse Aide (CNA) who was assigned to care for Resident #252. The CNA stated the resident was dependent on staff assistance for ADL care except for eating which the resident was able to do independently with setup. The CNA further explained that the CNAs were responsible for resident nail care and would cut resident nails when she saw they needed to be cut. The surveyor asked the CNA about Resident #252's nails and the CNA replied she was not sure. The CNA stated that she would check on Resident #252's nails after completing morning care for her last resident. On 2/13/26 at 10:49 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to care for Resident #252. The LPN stated Resident #252 was compliant with personal hygiene care. The LPN confirmed nail care was the CNAs' responsibility. The surveyor asked about Resident #252's fingernails. The LPN replied she was not sure and believed the resident's nails were last trimmed about 1 to 2 weeks ago. The LPN could not recall if she looked at the resident's nails today or yesterday. At that time, the LPN, accompanied by the surveyor, went to the resident's room to observe their fingernails. The LPN inspected Resident #252's fingernails and confirmed their fingernails were too long. The LPN stated Resident #252's nails needed to be cut, and it would be done today. The resident (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was agreeable with getting their nails trimmed short. On 2/18/26 at 2:17 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional of Clinicals (RC) about the concern for Resident #252's nail care. On 2/19/26 at 10:23 AM, the LNHA, the DON, and the RC met with the survey team. The DON stated Resident #252's long nails were inspected and cut on 2/13/26 after surveyor inquiry. Additionally, the resident's care plan was updated, and in-service education was being provided to staff. 2. On 2/12/26 at 11:17 AM, the surveyor interviewed Resident #234, who reported that they had been calling for help because they needed their adult brief changed. The surveyor observed that the resident's brief was soaked and with feces. It was also noted that the feces were nearly dry. Resident #234 mentioned that they did not know where their call bell was and that they screamed for help instead. The roommate assisted them in calling for help, as they sometimes cannot be heard. The resident stated that they had been waiting for almost an hour to be changed. On 2/13/26 at 9:43 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #234, which revealed the following: A review of the admission Record reflected Resident #234 was admitted with diagnoses that included but were not limited to; cerebrovascular (a condition that affects blood flow to the brain) disease and unspecified cataract (the lens of the eye becomes cloudy). A review of the annual MDS (A/MDS) dated [DATE], indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated that the residents had moderately impaired cognition. Further review of the A/MDS, as reflected in section GG, revealed that Resident #234 was dependent on staff assistance for ADLs, and in Section H – resident was always incontinent (loss of control) of both bowel and bladder. A review of the CP report initiated on 12/24/25 reflected a focus of the residents' potential for skin breakdown secondary to limited bed mobility and incontinence. Interventions included, but were not limited to, keeping skin clean and dry. On 2/12/26 at 11:19 AM, the surveyor interviewed the CNA #2, who stated that she was attending to another resident and would attend to Resident #234 as soon as she finished. On 2/12/26 at 11:20 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated that the CNA assigned to Resident #234 was attending to other residents. On 2/18/26 at 2:18 PM, the team of surveyors met with the Licensed Nursing Home Administrator, Director of Nursing, and the Regional Clinical Director regarding the above concern. There is no additional information provided. A review of the facility's Activities of Daily Living policy, last revised on October 2024 revealed: . The facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such deterioration was unavoidable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Activities of daily living include, but are not limited to.Hygiene-bathing, dressing, grooming, nail care, oral care. Under Procedure of the policy revealed: . 3. A resident who is unable to carry out activities of daily living will receive the necessary services from facility staff. 4. The staff will report or communicate any changed in the resident's usual performance and/or refusal of activities of daily living. to the assigned nurse. NJAC 8:39-27.1(a); 27.2(g)(h)

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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. Based on observation, interview and record review, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure appropriate dispensing and administration of a medication for 1 of 13 residents observed during medication administration. The deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.On 2/17/26 at 9:49 AM, the surveyor observed a Registered Nurse (RN) prepare medications to be administered to Resident #123. The medications removed from the medication cart included a DuoNeb (ipratropium/albuterol) 0.5-2.5 (3) milligram (mg) /3 milliliter (ml) solution (a prescribed, combination bronchodilator nebulizer solution used to treat airflow obstruction).The surveyor asked the RN to review the resident's DuoNeb medication packaging box. The RN looked in the drawer and stated there was no DuoNeb packaging box for Resident #123. The RN stated although it was not common practice, she would use a DuoNeb solution vial from another resident to administer the resident's due medication. The surveyor asked the RN about the availability of Resident #123's DuoNeb medication. The RN replied that it could be pharmacy delivery pending for the medication.The RN reviewed the Electronic Medical Record (EMR), confirmed the resident's medication was ordered yesterday evening, and it should be delivered later today. The surveyor asked the RN about the facility protocol. The RN replied that the pharmacy should be called to follow up about the medication. The RN proceeded to administer the borrowed DuoNeb medication to the resident.Upon leaving the room, the surveyor asked the RN if it was facility protocol to borrow medication from another resident. The RN replied that it was not. The RN stated it would be to call the pharmacy, notify the resident/resident's representative that the medication was not available; notify the physician and write a progress note.On 2/17/26 at 10:25 AM, the surveyor reviewed the EMR of Resident #123.The admission Record (a summary of important information about a resident) revealed Resident #123 had diagnoses that included but were not limited to; urinary tract infection, anxiety disorder and encephalopathy (any disease or dysfunction of the brain that alters its structure and function). A physician's order dated 2/7/25 indicated to give DuoNeb Solution 0.5-2.5 (3) mg/3 ml, one vial inhale orally via nebulizer two times a day at 9 AM and 5 PM for shortness of breath.On 2/17/26 at 12:21 PM, the RN informed the surveyor Resident #123's DuoNeb medication would be delivered at 1 PM by the pharmacy. The RN stated the physician was informed and a progress note was documented. On 2/17/26 at 12:40 PM, the surveyor informed the Regional of Clinicals (RC) about the above concern for Resident #123 observed during medication administration. The RC stated she would follow up and provide any additional information.On 2/18/26 at 8:58 AM, the surveyor informed the Director of Nursing (DON) in the presence of the RC about the concern for Resident #123 during medication administration observation. The DON acknowledged it was not facility practice to borrow medication from another resident and would follow up to provide any additional information. On 2/18/26 at 2:17 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the DON, and the RC about the above concerns.On 2/19/26 at 10:23 AM, the LNHA, the DON, and the RC met with the survey team. The DON stated the resident's DuoNeb medication was delivered as previously indicated; one to one education was provided to the RN, and all nurses were being educated that it was prohibited to borrow medication from another resident. The DON provided the DuoNeb packaging slip confirming delivery and staff education initiated. A review of the facility's Medication Administration Policy, last dated February 2025, included under Procedure of the policy (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed: .18. Documents all held, refused or unavailable medication on the EMAR [electronic medication administration record] and/or nurses' notes. Informs Physician in a timely manner when medications held, refused, or otherwise unavailable for administration.NJAC 8:39-27.1(a); 29.2

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure that the device used to identify call device notifications were functioning properly for 1 of 7 units.This deficient practice was evidenced by the following: On [DATE] at 11:00 AM, the surveyor observed the call light was on outside the resident's room [ROOM NUMBER], but there was no audible sound. The surveyor observed unit 12's call light system machine in unit 12's nursing station had no audible sounds, and no button lights were on. On the same day, the surveyor observed another call light was on outside of another room in unit 12, but there was still no audible sound, and no lights were on in the nurses' station call light system machine. On [DATE] at 11:18 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who stated that the call light and sound were off in the nurses' station, but she had informed the maintenance department about the call light machine. On the same day, the LPN/UM provided the surveyor with the Items for Maintenance form for unit 12; there was no handwritten request that the call light machine needed to be fixed by the maintenance department. The LPN/UM did not provide additional information. On [DATE] at 2;18 PM, the team of surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing, and the Regional Clinical Director regarding the concern above. On [DATE] at 11:47 AM, in the presence of the survey team, the LNHA acknowledged that the call bell sound was not working because the panel in the nurses' station was stuck. The LNHA added that maintenance had already fixed it. A review of the facility policy titled Call lights: Accessibility and Timely Response, revised on 7/25, revealed under Procedure 7. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. 8. Ensure the call system alerts staff members directly or goes to a centralized staff work area. NJAC 8:39-31.2(e)

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility documentation, it was determined that the facility failed to ensure handrails were secure and intact on 2 of 7 resident units. This deficient practice was evidenced by the following:1. On 2/13/2026 at 10:19 AM, the surveyor toured unit 8, 2nd floor and observed the following: -a handrail located across from emergency exit door, near the pay phone, next to room [ROOM NUMBER], was coming loose away from the wall. On 2/13/2026 10:24 AM, the surveyor interviewed the Certified Nursing Aide (CNA) on the unit, who stated if something was broken, she would report it to the nurse, who would then notify maintenance. She stated she was unaware of the loose handrail. On 2/13/2026 at 10:32 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1, for unit 8. LPN #1 stated if something was broken, he would call maintenance and enter it into the maintenance logbook (MLB). LPN #1 provided the surveyor with the MLB. A review of the MLB from October to present did not reveal an entry for the loose handrail. On 2/13/2026 at 11:42 AM, the surveyor interviewed the Director of Maintenance (DOM), who stated he tried to do environmental rounds monthly which included things like check call bells, furniture, walls, and lights. He stated he did morning rounds to check water temperatures and to review the maintenance books. At that time, the DOM stated he was very shorthanded. I am aware a lot of things need to be fixed, we are working on it. He stated he had tried to fix the handrail before but was unaware that it was broken again. 2. On 2/12/26 beginning at 10 am, the surveyor toured the first and second floors of Unit 11. A handrail outside of room [ROOM NUMBER] was noted to be loose and coming away from the wall. On 2/17/26 at 10:25 AM, the surveyor interviewed the Unit 11 Registered Nurse Unit Manager. The surveyor reviewed the area of concern with her. She stated the maintenance department does environmental rounds. She showed the surveyor the MLB located at the nursing desk. The surveyor noted that not all concerns were signed off as completed going back to 9/2025 and there was no documentation regarding loose handrails. On 2/18/2026 at 2:19 PM, the survey team discussed the loose handrails with the Administrator and the Director of Nursing (DON). On 2/19/2026 at 10:25 AM, the Administrator and DON responded to the survey team's environmental concerns. They stated the loose handrails would be fixed. The facility policy titled Resident Environment, revised 10/2024, indicated housekeeping and maintenance services will be provided to maintain a safe, sanitary, orderly, and comfortable interior (procedure #4). NJAC 8:39-31.4(a-f)