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 _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE JERSEY CITY, NJ 07307**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS C #: NJ100164604 Sample Size: 3 Census: 135 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		

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

Electronically Signed | 05/09/2024

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060905	A. BUILDING: _____ B. WING _____	C 04/24/2024

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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S 000	Initial Comments C #: NJ100164604 Sample Size: 3 Census: 135 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C #: NJ100164604 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 6 of 28 day shifts. The deficient practice was evidenced by the following:	S 560	Staffing coordinator will be in-serviced by administrator, on meeting ratios needed for CNA's. Staffing coordinator will notify DON/ADON of any ratios not met. In-service done for nursing management on ration of CNA's to residents needed. The ratio's will be one CNA to 8 residents for day shift. One CNA to 10 residents for evenings and one CNA, to 14 residents for nights.	5/9/24

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

Electronically Signed | 05/09/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060905	A. BUILDING: _____ B. WING _____	C 04/24/2024

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift, one direct care staff member to every ten residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties, and one direct care staff member to every fourteen residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 4/30/23 to 5/6/23, 05/07/2023 to 5/13/23, 4/7/24 to 4/13/24, and 4/14/24 to 4/20/24. For the 2 weeks of staffing from 04/30/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -04/30/23 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -05/07/23 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -05/13/23 had 15 CNAs for 134 residents on the day shift, required at least 17 CNAs. For the 2 weeks of staffing from 04/07/2024 to	S 560	All residents may be affected by staffing ratio issues. They may be identified by reviewing staffing sheets daily and census numbers. Staffing ratios will be monitored by DON/ADON/Designee weekly and will be initialed by reviewer. Don/ADON will document whether weekly ratio was met for all shifts. Review of weekly ratio will be documented. Administrator or designee, will randomly review 1 week per month of CNA staffing. Results will be reported to the QA committee by the Administrator. Completion date 5/24/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060905	A. BUILDING: _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 04/20/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts and deficient n total staff for residents on 1 of 14 overnight shifts as follows: -04/07/24 had 15 CNAs for 129 residents on the day shift, required at least 16 CNAs. -04/14/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -04/20/24 had 9 total staff for 134 residents on the overnight shift, required at least 10 total staff.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060905		5/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/09/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO