STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315344	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optima Care Castle Hill	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of pertinent facility documents on 01/12/26, it was determined that the facility failed to maintain a safe environment during supervision by staff of a severely cognitively impaired resident (Resident #1) who was a high risk for elopement, had poor safety awareness, and exit-seeking behaviors.On 12/30/25, Resident #1 was able to open the 6th floor [NAME] side alarmed exit door, went down ten flights of stairs and exited through the side door of the facility on to the street. At approximately 4:00 PM, Licensed Practical Nurse (LPN) #1 alerted the nurse management that the resident was nowhere to be found. The last sighting of the resident was approximately at 3:25 PM by LPN #1 when the resident was seen ambulating the hallway on the 6th floor towards the high side of the Unit near the exit door. It was probable that the resident exited the 6th floor door through the stairwell which alarmed. The resident was found by the local police at approximately 9:00 PM. According to the Licensed Nursing Home Administrator (LNHA), the resident's family called them and stated the police found the resident. The resident was brought to the emergency department (ED) for evaluation and stayed overnight. The facility's failure to ensure a safe environment during supervision of a severely cognitively impaired resident at risk of elopement, with poor safety awareness, and exit seeking behaviors placed Resident #1 at risk.This posed the likelihood of serious physical harm, injury, or death which resulted in an immediate jeopardy (IJ) situation. The IJ began on 12/30/25 at 3:25 PM when LPN #1 had last sighting of the resident walking the hallway on the 6th floor towards the high side of the unit near the exit door and sitting on a couch in the hallway. The facility's administration was notified of the IJ on 01/12/26 at 5:30 PM. The facility submitted an acceptable Removal Plan (RP) on 01/13/26 at 3:38 PM. The surveyor verified the implementation of the RP on-site during the continuation of the survey on 01/15/26. The deficient practice was evidenced as follows: A facility policy, Elopement and Wandering Residents, revised on 03/2025 included: Policy: This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their plan of care. Under Procedures, 1. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering .evaluation and analysis of hazards and risks .; 2. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering: a. Residents will be assessed for elopement and unsafe wandering upon admission .b. Interventions to increase staff awareness of the resident's risk .c. Adequate supervision will be provided to help prevent accidents or elopements. A review of the Reportable Event Record/Report (FRE) submitted by the facility to the New Jersey Department of Health (NJDOH) on 12/30/25, revealed the date and time of event as 12/30/25 at 4:00 PM. The FRE included under Narrative that at approximately 4:00 PM, Resident #1 was nowhere to be found. The building was searched room to room and the surrounding area within a mile was also searched by foot. The FRE revealed under Narrative, 3) Wander Guard was utilized, (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	indicating that the resident had a wander guard.A review of the facility's Summary of Investigation (SI) with a date of event of 12/30/25, revealed that at approximately 4:00 PM on 12/30/25 LPN #1 alerted nurse management that Resident #1 was nowhere to be found. Immediately a room to room and in-house searches were initiated. The search continued outside. Local police were informed about the missing resident, as well as Resident #1's family and hospitals. It was probable that the resident exited through the 6th floor unit door, as an audible door alarm sound was heard. Staff responded to the audible alarm and looked at the stairwell, but no one was in sight. The SI indicated that the resident had a Brief Interview of Mental Status (BIMS) score of 2, indicating severe cognitive impairment and judgment, poor safety awareness and had an inability to recognize environmental hazards. The resident was able to ambulate independently. The SI further indicated that the resident was admitted to the facility from the hospital following a significant fall prior to admission which necessitated a craniotomy [brain surgical procedure] resulting from traumatic subdural hematoma [accumulation of blood in the brain]. The SI revealed that Resident #1 was found by local police at approximately 9:00 PM on 12/30/25. The resident was brought to the ED for evaluation and stayed there overnight. The resident returned to the facility the next morning and was re-assessed by the nurse practitioner (NP). The resident was requested to re-enact the process of their way off of the unit. The SI indicated that the resident led facility staff to the northside stairwell and admitted to opening the emergency door and proceeded down to the egress door towards the local street. A review of the staff statements obtained by the facility during investigation revealed: -LPN #1 statement: According to LPN #1 when they arrived on the 6th floor to work the 3-11 shift, the resident was sitting inside the nurse's station. LPN #1 further stated that after making rounds, counting narcotics, taking endorsement from the 7-3 shift nurse, LPN #1 noticed the resident was not in his wheelchair anymore. This was approximately 3:25 PM. LPN #1 stated they looked around and saw Resident #1 nearby, slowly ambulating and then sitting on the couch along the high side hallway. After reading the 24-hour report [endorsement report] LPN #1 went to look for Resident #1. Resident #1 was no longer on the couch. This was approximately 3:35 PM. LPN #1 began a room search of the 6th floor. LPN #1 saw the DON and reported that Resident #1 could not be found. All staff were alerted and LPN #1 continued to look for the resident on every floor and exit stairs multiple times. -Certified Nursing Assistant (CNA)#1, 3-11 shift: According to CNA#1 when they came to the floor at 3:30 PM, they were looking for the resident and did not see them.-Registered Nurse (RN) #1, 3-11 shift: RN #1 was sitting at the nurse's station getting report from nurse going off shift and Resident #1 was seated in wheelchair in the back of nurse station. It was around 3:15 PM and that was the last time RN #1 saw the resident. -Social Worker (SW): The SW's office was across from the [NAME] alarmed exit door on the 6th floor. The SW came back to the 6th floor from a meeting, as they came off the elevator they heard an alarm. The SW was going to their office and realized the alarm was coming from the exit door across from their office. The SW deactivated the door alarm and went to look down the stairs but did not see anyone. The SW went back to the floor and as they were going down the hallway to inform nursing staff, they saw LPN #1 and reported that the exit door was alarming and that they checked down the stairs and did not see anyone. The SW and LPN #1 then went down the stairs all the way down to bottom and noted that the exit door on the ground floor was partially opened. SW and LPN #1 checked outside the door that led to outside to local street and did not see any residents from the facility. A review of the Police Report (PR) titled Incident Report, a document submitted by the local and neighboring town police department, revealed that on December 30, 2025, at 4:17 PM the police were dispatched to [street redacted] on a missing person report. The police met with the Licensed Nursing Home Administrator (LNHA) who (continued on next page)

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