STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Connection Rahway	865 Stone Street Rahway, NJ 07065

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 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** 27193 Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to provide appropriate incontinence care for 1 of 2 residents reviewed for Activities of Daily Living (Resident #75 who required extensive assistance from staff for care. The deficient practice was evidenced by the following: On 08/20/24 around 8:45 AM, the surveyor toured the North Wing of the facility. At 8:49 AM, while touring the unit, a strong malodorous odor of feces was permeated in the hallway next to Resident #75's room. The surveyor observed a Certified Nursing Assistant (CNA) exited the room. Resident #75 was in the bed fully covered. Resident #75 nodded the head to the surveyor's greetings and kept the head down. The surveyor asked the resident how was life here at the facility, Resident #75 did not answered. The surveyor met the CNA in the next hallway and summoned her to the room. The surveyor informed the CNA that she would like to perform a care tour. The CNA entered the room, checked Resident #75 for incontinence. Resident #75 was soiled with urine and feces. The surveyor and the CNA we both observed that Resident #75 had 2 adult briefs on which were saturated with urine Resident #75 had a dressing to the sacral area that was saturated with urine and bloody drainage. The bed padding were saturated with urine. the The CNA informed the surveyor that she reported to work at 7:00 AM this morning, she got report from the nurse and did not receive report from the CNA who worked from the 7:00 PM-7:00 AM shift. The CNA added that she had not provided care yet to Resident #75. The surveyor asked the CNA to call the charge nurse. At 8:55 AM, the charge nurse entered the room and verified that Resident #75 had 2 adult briefs on which were saturated with urine. The blue pads used to protect the bed were all saturated with urine. The surveyor then interviewed the charge nurse who stated that all residents were to have one brief on. When asked how the staff will know, the charge nurse replied, The staff had been educated. On 08/21/24 at 10:30 AM, the surveyor reviewed Resident #75's electronic medical record. The Admission Face Sheet (an admission summary) reflected that Resident #75 was admitted to the facility with diagnoses which included but were not limited to; acute respiratory failure with hypoxia, depression, unspecified dementia, unspecified severity without behavioral disturbances, mood disturbance and anxiety. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Admission Minimum Set (MDS) dated [DATE], reflected that Resident #75 received a score of 15 on the Brief Interview for Mental Status (BIMS) indicative of intact cognition. However interview with staff revealed that Resident #75 was confused. Review of Resident #75's plan of care revealed a focus for decline in Activities of daily living Self Care Performance related to Activity Intolerance, impaired balance, limited mobility and musculo-skeletal impairment due to recent hospitalization , initiated 08/02/24. The goal was for Resident #75 will improve current level of function in Mobility, transfers, dressing, toilet use and personal hygiene also initiated 08/02/24. Resident #75 had also a focus for incontinence related to disease process, initiated 08/15/24. The goal was for Resident #75 to decrease frequency of urinary incontinence through the next review date of 10/31/24. The interventions included, uses disposable briefs. Change frequently and as needed. An intervention added on 8/20/24, was that Resident #75 prefers using 2 adult briefs to wick away urine and keep feeling dry. According to the care plan history, the Director of Nursing added this intervention on 8/20/24 after the charge nurse verified with the surveyor that Resident #75 had 2 adult briefs on which were saturated with urine. On 08/21/24 at 09:34 AM, the surveyor interviewed the CNA who cared for Resident #75 on 8/20/24. The CNA stated that Resident #75 can partially assist with care, can stand and pivot and sometimes was aware of their incontinence needs. The CNA stated that the CNA who provided care to the resident from 11:00 PM-7:00 AM shift left the resident with the 2 briefs on. The CNA added that she got report from the nurse regarding the resident. The CNA stated that on the morning of 8/20/24 she served and set the breakfast tray for Resident #75 and did not checked Resident #75 for incontinence prior to breakfast. The CNA added that she was not familiar with Resident #75's routine. The CNA stated that she did not get report from the CNA who worked the night shift and was not aware of the time that incontinence care was last provided. On 08/21/24 at 10:30 AM, the surveyor again interviewed the Registered Nurse (Charge nurse) who was in the room with the CNA and witnessed Resident #75 with the two adult briefs. The RN stated that Resident #75 should not have 2 adult briefs on. On 08/22/24 at 12:50 PM, the above concerns were discussed with the DON in the presence of the Licensed Nursing Home Administrator and the Regional Nurse. The surveyor asked the DON regarding her expectations regarding incontinence care. In the presence of the survey team, the DON stated that residents were to have one adult incontinent brief on. The DON further added, that heavy wetter at times would have 2 adult briefs on when requested The DON added that Resident #75 would not allowed staff to provide incontinence care while playing cards. The surveyor informed the DON that in the morning of 8/20/24 at 8:40 AM, Resident #75 was in bed fully covered. The CNA admitted that she set up the breakfast tray and did not checked Resident #75 prior to breakfast. According to staff breakfast was served around 7:30 AM-7:45 AM on 8/20/24. Resident #75 assessed by the facility as having impaired cognitive function related to dementia or impaired thought process was totally dependent on staff for all activities of daily living. During the survey, the surveyor attempted to interview Resident #75 on 8/20/24 at 8:35 AM and again on 8/21/24 at 10:30 AM, Resident #75 was unable to proceed with the interview. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/23/24 at 11:52 AM, the CNA who worked the 7:00 PM-7:00 AM shift, returned the call. The CNA informed the surveyor that she did not provide care to the resident in the morning. The CNA stated that another CNA who worked the 3:00 PM- 11:00 PM cared for Resident #75 and placed the double briefs on the resident around 12:00 PM. The CNA stated on 8/20/24 around 4:00 AM when she went to the room Resident #75 was sleeping and did not want to be checked for incontinence care. She did not return to the room nor inform the nurse that Resident #75 was not cared for during the shift. According to the interview with the CNA, almost 9 hours had elapsed since Resident #75 was provided with incontinence care. The surveyor then asked the CNA how often that she would observed other residents who were incontinent with 2 briefs on. The CNA stated the residents that were incontinent would have two adult briefs on. The first brief will be placed inside the second brief to contain the urine and would not be snapped. When asked if she reported the concerns to the nurses or the DON she stated, No. A review of the policy for Activities of Daily Living last revised 1/2024, provided by the facility on 8/21/24 indicated the following: Residents shall receive assistance with activities of daily living (ADLs) every shift, as appropriate. The facility's policy for incontinence care indicated that the facility shall provide care for all incontinent residents. NJAC 8:39-27.1(a),