STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315299	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King Manor Care and Rehabilitation Center	2303 West Bangs Ave Neptune, NJ 07753

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 - Some	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 Complaint # NJ 168449 Based on observation, interview, record review, and review of facility provided documents it was determined that the facility failed to consistently provide appropriate and timely incontinence care for residents who were dependent on staff for Activities of Daily Living (ADLs) care. This deficient practice was identified for 2 of 3 residents (Resident #3 and #184) reviewed for ADL care and was evidenced by the following: 1. On 10/21/24 at 8:20 AM, the surveyor conduced an initial tour of the [NAME] Unit and observed a strong urine odor in the hallway. On 10/21/24 at 8:21 AM, the surveyor observed Resident #3 in bed in their room. The surveyor inquired regarding the care received at the facility, and Resident #3 stated that they were soiled and needed to be changed. The resident, then activated the call light, and stated that staff took a long time to answer the call light. Resident #3 stated sometimes it could take one hour for staff to answer the call light and incontinence care was not provided timely. The surveyor exited the room and informed the certified Nursing Assistant (CNA #1) in the next hallway of Resident #3's request. The CNA informed the surveyor that she was on light duty but she would get another CNA to assist. On 10/21/24 at 8:45 AM [24 minutes later], CNA #2 entered the room to provide incontinence care to Resident #3. The surveyor observed that the incontinence brief was bulging from the front to the back, and Resident #3 was wearing two incontinent briefs which were both saturated with urine and feces. The surveyor observed that the bed pad was yellow stained. CNA #2 then informed the surveyor that she had not yet provided care to the resident. On 10/21/24 at 11:30 AM, the surveyor interviewed CNA #1 who confirmed she delivered the breakfast tray to the resident around 7:50 AM. CNA #1 stated she did not ask the resident if they were soiled and did not check to see if they needed incontinence care prior to providing the resident with the breakfast meal. On 10/23/24 at 9:04 AM, the surveyor entered the room and observed Resident #3 was in bed. A CNA was also in the room and Resident #3 stated in the presence of the CNA the they were last changed yesterday, referring to the 3:00 PM to 11:00 AM shift. The incontinence brief was again observed bulging to the front and Resident #3 was soiled with feces and urine. The bed pad to protect the bed was again observed yellow stained. (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 - Some	On 10/24/24 at 8:32 AM, the surveyor observed Resident #3 in bed. Resident #3 stated that they already ate breakfast. When inquired if they received incontinence care, Resident #3 stated in the presence of the Licensed Practical Nurse (LPN), I was last changed yesterday. The LPN checked the resident with the surveyor present and observed that the brief was soiled with urine and feces. On 10/24/24 9:40 AM, a telephone interview was conducted with CNA #2 who provided care to Resident #3 on 10/21/24 who stated that she provided incontinence care to the resident at 5:00 AM. CNA #2 stated that she placed two incontinent briefs on Resident #3 because the resident requested two briefs. She then stated that did not inform the nurse that she had been placing two briefs on the resident. When inquired about what could happen with two briefs that were saturated with urine and feces, she stated the skin could break down. On 10/24/24 at 10:30 AM, the surveyor reviewed Resident #3's medical record which revealed the following: -Admission Record (AR) revealed, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: Anemia, difficulty walking, acute respiratory failure with hypoxia, metabolic encephalopathy. -The quarterly Minimum Data Set (MDS) assessment tool dated 09/16/24, revealed that Resident #3 had intact cognition. Resident #3 received a score of 15 out of 15 on the Brief Interview for Mental Status (BIMS). Section G of the MDS which referred to Activities of Daily Living (ADLs) revealed that Resident #3 was totally dependent on staff for care. -Review of the Care Plan for Resident #3 initiated on 06/08/22, included a Focus for ADL Self Care Performance Deficit related to: Activity intolerance, fatigue and impaired balance. The goal was for Resident # 3 to improve current level of function in bathing, dressing, toileting, transfers and walking through the review date. Revised 03/07/2024. The interventions were to provide all necessary supplies for each ADL task and assist as needed. The care plan did not indicate the frequency for staff to provide incontinence care to the resident. On 10/24/24 at 9:39 AM, the surveyor interview the Registered Nurse/ Unit Manager (RN/UM) regarding Resident #3's incontinence care. The RN/UM revealed that she was not aware that direct care staff were placing two incontinent briefs on the resident. The RN/UM stated she was made aware on 10/21/24 of the double incontinent briefs being used on residents. The RN/UM added that double briefs should not be used on residents as they could cause skin irritation. When inquired regarding the frequency of incontinence care should be provided, the UM stated that incontinence should be provide every two hours. The 7:00 AM- 3:00 PM shift were supposed to check residents for incontinence care as soon as they received their assignment. The surveyor asked about Resident #3 wearing two incontinent briefs and she stated that staff should only apply only one incontinent brief and Resident #3 did not request double briefs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 10/21/24 at 9:30 AM, the surveyor entered a room and observed Resident #184 in bed. Resident #184 stated that incontinence care was not being provided in a timely manner. Resident #184 stated that they wore a Condom Catheter (a gender specific external catheter to facilitate urinary flow) and all the staff did not know how to properly apply the Condom Catheter (CC). The resident stated that most of the time the CC would be dislodged and they would be wet and staff did not check for incontinence care in a timely manner. Resident #184 added sometimes staff would not be available for 4 to 5 hours. The CC would be leaking and they would be soaked with urine. The surveyor then asked Resident #184 to activate the call light, and a CNA entered the room within 5 minutes and inquired regarding the call light. The CNA assisted with the incontinence care and the surveyor observed Resident #184's hospital gown and incontinence brief was soaked with urine. Resident #184 informed the surveyor that they were not checked during the night, or before breakfast. The CNA confirmed that she did not check Resident #184 prior to serve the breakfast meal. On 10/23/24 at 8:00 AM, the surveyor reviewed Resident #184's medical record which revealed the following: - The admission Face Sheet, an admission summary revealed that Resident #184 had diagnoses which included but were not limited to; quadriplegia (severe medical condition characterized by the partial or total loss of function in all limbs and the torso). -The Admission Minimum Data Set (MDS), dated [DATE], an assessment tool used by the facility to prioritize care reflected that Resident #184 was alert and able to make their needs known. Resident #184 received a score of 15 on the Brief Interview for Mental Status (BIMS) indicative of intact cognition. -Resident #184 care plan had a Focus for ADLs self-care performance deficit related to quadriplegia, initiated 08/05/24. The goal was for Resident #184 to improve current level of functioning. Interventions included: Provide all necessary supplies for each ADL task and assist as needed. Resident #184 is totally dependent on staff for toilet use. On 10/23/24 at 11:30 AM, the surveyor reviewed the TASK (electronic record where the CNA documented the care provided to each resident). The ADL task page which included toileting was left blank for 10/21 and 10/22. On 10/24/24 at 12:30 PM, during the pre-exit conference with the Assistant Administrator (AA) and Director of Nursing (DON), the above findings were presented. A review of the facility policy titled, Activities of Daily Living (ADL) Supporting, last revised 2018, indicated the following: Policy Statement revealed: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and persona and oral hygiene. (continued on next page)

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