MSDH - Health Facilities Licensure and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25MA	A. BUILDING: _____ B. WING _____	C 11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTAN NURSING AND REHABILITATION CENTI	4540 MANHATTAN RD JACKSON, MS 39206

(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
M 000	Initial Comments The State Agency (SA) conducted a complaint survey, CI MS #18242 and CI MS #18244 at the facility from 11/01/21 through 11/05/21. During the survey, the SA did not substantiate CI MS #18242 related to Resident Safety/Accidents (elopement). The SA substantiated CI MS #18244 related to failure to provide Resident Services per Physician Orders/Care Plan. Tthe SA found the facility not to be in compliance with the requirements of the Minimum Standards for Institutions for the Aged or Infirm. The SA identified an Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) beginning on 9/14/21 The facility failed to provide free water flushes, (recommended by the registered dietician) for forty-three (43) days with resulted in the resident being hospitalized, intubated and placed on a ventilator due to hypovolemic shock. The facility's failure to provide adequate hydration for forty-three (43) days for Resident #2 with a history of Gastrostomy and Dysphagia caused Resident #2 serious harm and placed other residents who received enteral feedings in a situation that is likely to cause serious injury, harm, impairment, or death. The SA notified the facility's Administrator of the IJ and SQC on 11/03/21 at 3:30 PM. The IJ and SQC existed at Rule 45.21.7 Gastric Feeeding (M635) and 45.21.10 Hydration (M650). The facility provided an acceptable Removal Plan on 11/04/21, in which the facility alleged all corrective actions were completed to remove the IJ on 11/04/21, and the IJ removed on 11/04/21.	M 000		

Mississippi State Department of Health

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

Electronically Signed | 11/30/21

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M 000	Continued From page 1 The SA validated the removal plan on 11/5/21 and determined the IJ was removed on 11/04/21 prior to exit, and the scope and severity for Rule 45.21.7 Gastric Feeding (M635) and 45.21.9 Hydration (M650) was lowered to a Level II while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. At the time of the survey, the facility had a census of 159 and held a license of 180 beds.	M 000		
M 635	45.21.7 Gastric feeding Gastric feeding. Residents who are eating alone or with assistance are not fed by a gastric tube unless their clinical condition indicates that the use of a gastric feeding tube is unavoidable. The residents who are fed by a gastric tube receive the treatment and services to prevent complications or to restore if possible, normal eating skills. This Statute is not met as evidenced by: Level IV Based on record review, facility policy review, and staff interview the facility failed to ensure Resident #2 received free water flushes through his Percutaneous Endoscopic Gastrostomy (PEG) tube to maintain adequate hydration status which resulted in Resident #2 becoming Hypovolemic (Dehydrated), resulting in Resident #2 being transferred to the local hospital and admitted with diagnoses of Hypovolemic Shock, Hypernatremia, Lactic Acidosis and Hyperchloremia for one (1) of (16) residents reviewed who have enteral feedings and water	M 635	M635 1. Resident #2 was in hospital from 10/27/21 □ 11/16/21. Resident #2 returned from hospital to facility 11/16/21 around 5:00pm. Resident #2 was evaluated for dehydration risk by licensed nurse on 11/16/21. Resident #2 physician orders were reviewed by the Nurse Practitioner11/16/21 and Physician on 11/17/21. Registered Dietitian evaluated resident # 2 on 11/17/21 with no recommendations. 2. All residents with enteral feeding have	12/6/21

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M 635	Continued From page 2 flushes.Resident #2. On 9/04/21 the Registered Dietician (RD #1) reviewed nutrition and hydration requirements for Resident #2 and made a recommendation to change the tube feeding orders for Resident #2 which included 175 milliliter free water flushes every four (4) hours. The physician (MD #1) reviewed the recommendations and approved them and issued physician orders based on the recommendations. On 9/14/21 the facility failed to include free water flushes in the transcription of the physician orders which led to the tube feeding complication of inadequate hydration for Resident #2 after 9:00 AM on 9/14/21. The facility's failure to provide adequate hydration for forty-three (43) days for Resident #2 with a history of Gastrostomy and Dysphagia caused Resident #2 serious harm and placed other residents who received enteral feedings in a situation that is likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 9/14/21 when the facility failed to ensure the physician ordered dietary recommendations was in place to provide adequate hydration for Resident #2. The facility Administrator was notified of the IJ at 3:30 PM and provided the IJ templates. The facility provided an acceptable Removal Plan on 11/04/21, in which the facility alleged all corrective actions were completed to remove the IJ on 11/04/21, and the IJ removed on 11/04/21. The SA determined the IJ was removed on 11/04/21 prior to exit, and the scope and severity for M635 was lowered to a Level II, while the facility develops and implements a plan of	M 635	the potential to be affected by the alleged deficient practice. 3. Licensed Nurses and Certified Nursing Assistants have been inserviced by the Director of Nursing/ Supervisor Nurse starting 11/3/21 and ongoing related to signs/symptoms dehydration, Registered Dietitian recommendations, physician orders for enteral formula, free water flushes, documentation of enteral formula and water flushes on medication administration record (MAR) with the plan of care reviewed/revised as indicated, and to ensure that residents are receiving enteral feedings/water flushes as physician ordered and recommended amounts of feedings and flushes to equal the daily ordered and recommended amounts. A Directed Inservice was conducted 11/29/21 by an external Registered Nurse regarding development/implementing comprehensive care plans, nutrition/hydration status maintenance-providing sufficient fluid intake, tube feeding management/restore eating skills-providing appropriate treatment and services with licensed nurses. Residents with enteral feeding/flushes plan of care have been reviewed/revised by the Director of Nursing services starting 11/3/21 and ongoing related to residents tube feeding formulas and water flushes. Registered Dietitian dietary recommendations will be given to the Director of Nursing starting 11/3/21 monthly for physician approval, completion, care plan, and maintenance of documentation/completion filed in a binder	

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M 635	Continued From page 3 correction and monitors the effectiveness of the systemic changes to ensure the facility sustains compliance with regulatory requirements. Findings include: Record review of facility policy titled "TUBE FEEDING" dated 7/18 revealed, "Residents with a ...Gastrostomy ... tube will be provided nutrition and hydration via the feeding tube.". Record review of the Face Sheet for Resident #2 revealed Resident #2 was admitted to the faciilityon 12/13/13 with the diagnosis of Paranoid Schizophrenia. He currently has diagnoses which include Diabetes, Gastrostomy, Dysphagia, Hypertension and Retention of urine. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/02/21 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of eight (8) which indicated Resident #2 had moderate cognitive impairment. Record review of Medical Nutrition Recommendations for Resident #2 dated 9/04/21, revealed RD#1's recommendation was listed as "Give Glucerna 1.5 continuous at 60ml/hr (milliliters per hour) for 24 hours. Flush 175 ml every 4 hours. Provides: 2160 kcal/ 118 gm (kilocalories/gram) PRO (protein)/2144 free water". Record review of Departmental Notes dated 9/16/2021 at 9:39 AM, "Role: Dietary" revealed " ...Flush 175ml (milliliters) q (every) 4 hrs (hours) to provide total free water 2144ml." Record review of Electronic Medication	M 635	in Medical Records office. The Director of Nursing Services/RN supervisors will complete Enteral Feeding Audits for residents with dehydration risk, enteral feedings, Registered Dietitian recommendations/ completion, care plan reviewed and revised to include enteral feeding formula and flushes, physician orders for enteral formula and water flushes to ensure accuracy and documentation three times weekly times four weeks, two times weekly times two weeks, and once weekly times six weeks starting 11/3/21. 4. Corrective actions will be monitored by the Quality Assurance Performance Improvement (QAPI) Committee monthly starting 11/3/21 with reports by the Director of Nursing monthly times three months regarding Enteral Feeding Audits results reviewed to ensure that residents are receiving enteral feedings per physicians orders and recommended amount of feeding and flushes to equal daily ordered and recommended amounts per the plan of care. The QAPI Committee will make recommendations for change to the plan if indicated. The Director of Nurses is responsible for ongoing monitoring and compliance. Completion date: 12/6/21	

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Administration Record (EMAR) for the month of September 2021 for Resident #2 revealed he had "Free water flush 150 cc six (6) times a day through 9:00 AM on 9/14/21.

Record review of EMAR for the months of September and October 2021 for Resident #2 revealed he had no "Free water flush" after 9:00 AM on 9/14/21.

Record review of "RESIDENT ISSUES FOR (MD #1)", (Nurse-Physician communication binder) revealed an entry dated 10/19/21 for Resident #2, "Behavior seems normal but resident appears pale and weak". The entry was signed by Nurse Practitioner (NP#1) for the resident's primary physician on 10/22/21. There was also an entry dated 10/26/21 for Resident #2 which stated "weak, pale, eyes sunken." This entry was crossed out with a note indicating that the resident had been transferred to the hospital on 10/27/21.

Record review of the Physician Orders for October 2021 for Resident #2 revealed orders for "NPO"(Nothing by mouth) dated 4/05/21. Send resident to (Proper Name of Local Hospital) for evaluation related to respiratory distress and temperature 100.8 dated 10/27/21 at 3:05 AM. There were no Physician Orders for water flushes included in the Physician Orders.

Record review of the "History and Physical" from the hospital admission for Resident #2 dated 10/27/21 revealed Resident #2 was admitted to the hospital with admitting diagnosis of 'Shock ...Most likely multifactorial, could be septic and hypovolemic... Active Problems included "Acute kidney injury, Hypernatremia, Hyperchloremia". The hospital records indicated Resident #2 was

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M 635	Continued From page 6 Record review of Departmental Notes dated 10/27/21 at 3:00 AM, "Role: Nursing" revealed, "2:40 AM upon entering room, resident appeared to have respiratory distress. Unresponsive. BP (blood pressure) 89/59, T (temperature) 100.8, R (respiration rate) 28, P (pulse) 125. Fingers appear swollen. Top of mouth is discolored and dry... 2:45 AM. (Formal Name of MD #1) notified of resident condition and N.O. (new order) send resident to (hospital) for evaluation ..." 0n 11/02/21 at 3:40 PM, an interview with the Director of Nurses (DON) revealed when asked how do you monitor the resident's fluid intake, including enteral feeding if applicable, the DON responded "Follow physicians orders. Actual measurement is usually documented on the MAR". When asked what potential hydration deficits has the resident experienced, the DON states she is not aware and doesn't know. When asked what other limitations or factors impact the resident's hydration, the DON responded, "Medications is the only thing I know of". When asked how do you ensure the resident is provided with adequate fluids, the DON stated, "Physician orders and physician ordered lab work to be quantitative". When asked what, when, and to whom do you report changes in fluid intake, the DON responded, "The floor nurse reports it to the physician". The DON explained the Registered Dietician makes recommendations in writing, which are presented to the physician and if approved by the physician they are entered into the resident's record as an order by the Unit Manager or nurse. The DON stated if the physician orders based on the Registered Dieticians recommendations appeared differently on the physicians orders and Medication Administration Record (MAR), then it was considered a transcription error by the Unit	M 635		

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Manager or nurse. The DON acknowledged Resident #2 received a hypertonic tube feeding and did not receive free water flushes for forty-three (43) days.

On 11/02/21 at 2:24 PM, an interview with LPN #4, charge nurse revealed "Somedays I am the unit manager for the second floor. I transcribed what was on the paper as far as the flushes.". She could not explain why the 175 cc free water flushes listed on the Nutrition Recommendation sheet was not on the physician orders or MAR.

On 11/03/21 at 1:10 PM, an interview with RD #2 revealed she started work at the facility on 9/20/21. She stated RD #1 no longer worked at the facility. RD #2 stated Registered Dieticians use a clinical formula which involved residents' weight, height, diagnosis, and medications along with other factors to determine the appropriate amount for free water flushes for each resident with a feeding tube. She confirmed Resident #2 needed the free water flushes and stated the Glucerna 1.5 tube feeding would not have provided sufficient amount of water on its own. She stated she had not been notified that Resident #2 had any signs or symptoms of dehydration by the staff.

On 11/03/21 at 4:10 PM, an interview with the physician for Resident #2, MD #1, revealed he was familiar with the resident and his care. He stated he had been called on the evening of 10/26/21 and notified of signs and symptoms of level of consciousness change, elevated temperature and tachypnea for Resident #2 and had issued an order to send Resident #2 to the hospital for evaluation. MD #1 stated he was not aware Resident #2 was not receiving water flushes via his peg tube. MD #1 stated he had

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been apprized by the RD of the new dietary recommendations and agreed to the recommended changes without modification. MD #1 stated after he had issued new orders based on the RD recommendations, "they would be sent to nursing for the order to be transcribed". When asked how much he felt the lack of water had contributed to the hospitalization of Resident #2, MD #1 responded "It would be nice to be able to say it would have a neutral effect, but I cannot deny it would have had a significant effect".

REMOVAL PLAN
11/3/21

Manhattan Nursing and Rehabilitation

Removal Plan - IJ - Residents with tube feeding formula, water flushes, care plans

The facility was informed by state agency 11/3/21 3:30pm of an immediate jeopardy and substandard quality of care. The state agency provided the facility with IJ templates for F692, F693, F656.

The facility failed to transcribe the dietary registered dietitian recommendations correctly resulting in omission of free water flushes for resident number two.

The facility failed to provide resident # 2 sufficient fluid intake to maintain proper hydration and health by failing to transcribe the dietary recommendations correctly resulting in omission of free water flushes from 9/14/21 through 10/27/21 when resident was admitted to hospital for hypovolemic shock.

The facility failed to fully develop and implement a

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comprehensive care plan for resident # 2 as 10/6/21 care plan states "resident receives medication and hydration". Goal states "will show no signs and symptoms fluid volume deficit through1/2022" but had no approach for free water flushes as recommended by registered dietitian; with order start date of 9/14/21 to provide total free water of 2144cc.

Corrective actions:

1. On 11/3/21 at 10:00a.m. 100% audits sixteen of sixteen residents with enteral feedings and water flushes were initiated and completed on 11/04/2021 at 10:00am. to ensure accuracy of physician orders with documentation of enteral feeding and water flushes on the medication administration record (MAR). The audits were completed by supervisory registered nurses. There are 16 residents with feeding tubes in the facility on 11/4/21. Zero of 16 residents needed revision and/or corrections.

2. On 11/3/21 at 2:30pm licensed nurses and certified nursing assistants were in-serviced by supervisory registered nurses related to signs and symptoms of dehydration, residents with enteral feeding, orders for enteral formula, water flushes, documentation of enteral formula and water flushes on the medication administration record(MAR) with the plan of care reviewed/revised as indicated, and that residents are receiving enteral feedings as physician ordered and recommended amount of feedings and flushes to equal the daily ordered and recommended amounts. Licensed nurses and certified nursing assistants will not be allowed to work until they have been in-serviced.

3. On 11/4/21 at 12:00pm the sixteen residents

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with enteral feeding/water flushes plan of care have been reviewed by the Director of Nursing and MDS Coordinator. No revision was needed. and was completed 11/4/21 at 12:00pm related to residents enteral feeding physician ordered formula and water flushes.

4. On 11/3/21 at 3:45 pm. the Quality Assurance (QA) committee met to include Executive Director, Director of Nurses (also Infection Preventionist at present), Regional Clinical Operation nurse, Vice President of Operations, and Medical Director in regard to Immediate Jeopardy cited for failure to provide sufficient fluid intake, failure to provide resident enteral feeding as physician ordered, and failure to develop and implement a comprehensive person centered care plan to meet the resident needs. Corrective actions will ensure that residents are receiving enteral feedings per physician orders and recommended amount of feeding and flushes to equal the daily ordered and recommended amounts. Two (2) policies were reviewed- (1. Tube Feeding and 2. Care plan policy. No revisions were made to the policies. QA Committee decided to implement collection of registered dietitian recommendations upon completion by nursing staff per physician orders and will be retained by medical records for a minimum of one year. Director of Nursing Services/RN supervisory nurses will complete an enteral feeding audit on all residents with enteral feedings physician orders for formula and water flushes to ensure accuracy and documentation of enteral feeding and water flushes on the medication administration record daily.

5. On 11/3/21 at 3:30pm all sixteen residents (16) residents with enteral feedings were assessed for signs and symptoms of dehydration by supervisor

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registered nurses, completed 11/04/2021 at 10:00am with no residents found with concerns of dehydration. Dehydration risk assessments have been reviewed, updated, and completed on each resident with enteral feedings by supervisory registered nurses on 11/4/21 at 12:00pm.

6. On 11/3/21 at 8:00pm the Director of Nursing audited enteral feedings and evaluated sixteen (16) residents who are receiving enteral feeding per physician orders and recommended amount of feeding and flushes to equal the daily ordered and RD recommended amounts and verifying sufficient fluid intake approaches are on the person-centered comprehensive care plan.

7. Facility alleges relieving the immediacy of this immediate jeopardy on 11/4/21 at 2:00pm.

On 11/05/2021 SA entered facility for verification of Removal Plan for Immediate Jeopardy.

Validation:

1. On 11/05/2021 interview with director of nursing indicated audits were completed for all residents who resided in the facility which ensured accuracy of physician orders with documentation of enteral feedings and water flushes. SA validated through interview and record reviews for Residents #2, #3, #4, and #5 (along with all the other residents in facility on this date with feeding tubes) accuracy of feeding tube orders with water flushes on medication administration records with no revisions or corrections necessary.

2. On 11/05/2021 through interviews with Director of Nursing and Acting Director of

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M 635	Continued From page 12	M 635		

Nursing, and record review of facility "Educational In-Service Record" titled Tube Feedings / Care Plans / S/S Dehydration / Transcription of Tube Feeding Orders / Free Water Flushes for tube feeders" sign-in sheet, the SA validated that in-service was conducted for all nurses and certified nursing assistants related to signs and symptoms of dehydration, residents with enteral feedings, orders for enteral formula, water flushes, documentation of enteral feedings and flushes on the medication administration record with the plan of care reviewed/revised as indicated, and that residents are receiving enteral feedings and flushes as ordered by physician and recommended by the dietician to equal the daily ordered and recommended amounts. Through interviews with LPN #3, LPN #5, LPN #6, and CNA # 2 and CNA #3. Through interviews SA validated that nursing staff was not allowed to work until they had been properly in serviced.

3. On 11/05/2021 SA validated through interview with Director of Nursing that care plans of Residents #2, #3, #4, and #5 (and the other residents in facility on this date with feeding tubes) were reviewed related to residents enteral feedings and water flushes as physician ordered and dietary recommendations. Record review of residents #2 through #5 (and the other residents in facility on this date with feeding tubes) care plans indicate enteral feeding orders, flush orders, and observation for signs and symptoms of dehydration.

4. On 11/05/2021 through interviews with four (4) members of the Quality Assurance committee including the Director of Nursing (also the Infection Preventionist), the Acting Director of Nursing, the Administrator and the Registered Dietician and record review of facility "Monthly

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M 635	Continued From page 13	M 635		

Facility QA & A Minutes" sign-in sheet dated 11/03/2021 at 3:45pm; the SA validated a meeting of the QA & A committee regarding the Immediate Jeopardy for failure to provide sufficient fluid intake, failure to provide residents enteral feedings as physician ordered, and failure to fully develop and implement a comprehensive, person-centered care plan to meet the resident needs. Two (2) policies were reviewed: 1) Tube feeding Policy and 2) Care Plan Policy. No revisions were formulated to the policies. The committee did, however, decide to implement collection of Registered Dietician recommendations upon completion by nursing staff per physician orders and will be retained by Medical Records for a minimum of one (1) year. Also added will be an enteral feeding audit daily on all residents with enteral feedings and water flushes by Director of Nursing and RN supervisory nurses to ensure accuracy and documentation of enteral feedings and water flushes on the medication administration record.

5. On 11/05/2021 through interview with Director of Nursing and record review of facility "Evaluation of Dehydration Risk" assessment forms for Residents #2, #3, #4, and #5, (and the other residents in facility on this date with feeding tubes) dated 11/04/2021, and observation of Residents #2, #3, #4, and #5 for signs and symptoms of dehydration, SA validated that 100% of residents in facility with feeding tubes were assessed for signs and symptoms of dehydration with no resident found with signs or symptoms of dehydration.

6. On 11/05/2021 through interview with Director of Nursing and record review of facility "Physician Orders", facility "Department Notes - Category - Dietary", and facility "Daily Care Guide", SA

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M 635	Continued From page 14 validated 100% of residents requiring tube feedings are receiving enteral feedings and water flushes per Physician orders per Registered Dietician recommendations and are verifying sufficient fluid intake approaches on the person-centered comprehensive plan of care. 7. The SA validated on 11/05/2021 all corrective actions were completed as of 11/04/2021 and Immediate Jeopardy was removed on 11/04/2021 prior to exit.	M 635		
M 650	45.21.10 Hydration Hydration. Each resident shall be provided sufficient fluid intake to maintain proper hydration and health. This Statute is not met as evidenced by: Level IV Based on record review, facility policy review, and staff interview the facility failed to ensure Resident #2 received free water flushes through his Percutaneous Endoscopic Gastrostomy (PEG) tube to maintain adequate hydration status which resulted in Resident #2 becoming Hypovolemic (Dehydrated), resulting in Resident #2 being transferred to the local hospital and admitted with diagnoses of Hypovolemic Shock, Hypernatremia, Lactic Acidosis and Hyperchloremia for one (1) of (16) residents reviewed who have enteral feedings and water flushes. Resident #2. On 9/04/21 the Registered Dietician (RD #1) reviewed nutrition and hydration requirements for Resident #2 and made a recommendation to change the tube feeding orders for Resident #2 which included 175 milliliter free water flushes	M 650	M650 1. Resident #2 was in hospital from 10/27/21 □ 11/16/21. Resident #2 returned from hospital to facility 11/16/21 around 5:00pm. Resident #2 was evaluated for dehydration risk by licensed nurse on 11/16/21. Resident #2 physician orders were reviewed by the Nurse Practitioner11/16/21 and Physician on 11/17/21. Registered Dietitian evaluated resident # 2 on 11/17/21 with no recommendations. 2. All residents with enteral feeding have the potential to be affected by the alleged deficient practice. 3. Licensed Nurses and Certified Nursing Assistants have been inserviced by the Director of Nursing/ Supervisor Nurse	12/6/21

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M 650	Continued From page 15 every four (4) hours. The physician (MD #1) reviewed the recommendations and approved them and issued physician orders based on the recommendations. On 9/14/21 the facility failed to include free water flushes in the transcription of the physician orders which led to inadequate hydration for Resident #2 after 9:00 AM on 9/14/21.As a result, Resident #2 was transferred by emergency services to the local hospital emergency department, intubated, placed on a ventilator, required resuscitation, and was admitted to the local hospital critical care unit for eight (8) days. The facility's failure to provide adequate hydration for forty-three (43) days for Resident #2 with a history of Gastrostomy and Dysphagia caused Resident #2 serious harm and placed other residents who received enteral feedings in a situation that is likely to cause serious injury, harm, impairment, or death. The situation was determined to be an Immediate Jeopardy (IJ) that began on 9/14/21 when the facility failed to ensure the physician ordered dietary recommendations were implemented to provide adequate hydration for Resident #2. The facility Administrator was notified of the IJ on 11/03/21 at 3:30 PM. The facility provided an acceptable Removal Plan on 11/04/21, in which the facility alleged all corrective actions were completed to remove the IJ on 11/04/21, and the IJ removed on 11/04/21. The SA determined the IJ was removed on 11/04/21 prior to exit, and the scope and severity for M650 was lowered to a Level II while the facility develops and implements a plan of correction and monitors the effectiveness of the systemic changes to ensure the facility sustains	M 650	starting 11/3/21 and ongoing related to signs/symptoms dehydration, Registered Dietitian recommendations, physician orders for enteral formula, free water flushes, documentation of enteral formula and water flushes on medication administration record (MAR) with the plan of care reviewed/revised as indicated, and to ensure that residents are receiving enteral feedings/water flushes as physician ordered and recommended amounts of feedings and flushes to equal the daily ordered and recommended amounts. A Directed Inservice was conducted 11/29/21 by an external Registered Nurse regarding development/implementing comprehensive care plans, nutrition/hydration status maintenance-providing sufficient fluid intake, tube feeding management/restore eating skills-providing appropriate treatment and services with licensed nurses. Residents with enteral feeding/flushes plan of care have been reviewed/revised by the Director of Nursing Services starting 11/3/21 and ongoing related to residents tube feeding formulas and water flushes. Registered Dietitian dietary recommendations will be given to the Director of Nursing monthly starting 11/3/21 for physician approval, completion, care plan, and maintenance of documentation/completion filed in a binder in Medical Records office. The Director of Nursing Services/RN supervisors will complete Enteral Feeding Audits for residents with dehydration risk, enteral feedings, Registered Dietitian recommendations/ completion, care plan	

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M 650	Continued From page 16 compliance with regulatory requirements. Findings include: Record review of facility policy titled "TUBE FEEDING" dated 7/18 revealed "Residents with a ...Gastrostomy ... tube will be provided nutrition and hydration via the feeding tube.". Record review of the Face Sheet for Resident #2 revealed Resident #2 was admitted to the faciility on 12/13/13 with the diagnosis of Paranoid Schizophrenia. He currently has diagnoses which include Diabetes, Gastrostomy, Dysphagia, Hypertension and Retention of urine. Record review of the Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/02/21 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of eight (8) which indicated Resident #2 had moderate cognitive impairment. Record review of 'Medical Nutrition Recommendations' for Resident #2 dated 9/04/21, revealed RD#1's recommendation was listed as "...Give Glucerna 1.5 continuous at 60ml/hr (milliliters per hour) for 24 hours. Flush 175 ml every 4 hours. Provides: 2160 kcal/ 118 gm (kilocalories/gram) PRO (protein)/2144 free water". Record review of Departmental Notes dated 9/16/2021 at 9:39 AM, "Role: Dietary" revealed " ...Flush 175ml (milliliters) q (every) 4 hrs (hours) to provide total free water 2144ml." Record review of Electronic Medication Administration Record (EMAR) for the month of September 2021 for Resident #2 revealed he had	M 650	reviewed and revised to include enteral feeding formula and flushes, physician orders for enteral formula and water flushes to ensure accuracy and documentation three times weekly times four weeks, two times weekly times two weeks, and once weekly times six weeks starting 11/3/21. 4. Corrective actions will be monitored by the Quality Assurance Performance Improvement (QAPI) Committee monthly starting 11/3/21 with reports by the Director of Nursing monthly times three months regarding Enteral Feeding Audits results reviewed to ensure that residents are receiving enteral feedings per physicians orders and recommended amount of feeding and flushes to equal daily ordered and recommended amounts per the plan of care. The QAPI Committee will make recommendations for change to the plan if indicated. The Director of Nurses is responsible for ongoing monitoring and compliance. Completion date: 12/6/21	

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"Free water flush 150 cc six (6) times a day through 9:00 AM on 9/14/21.

Record review of EMAR for the months of September and October 2021 for Resident #2 revealed he had no "Free water flush" after 9:00 AM on 9/14/21.

Record review of "RESIDENT ISSUES FOR (MD #1)", (Nurse-Physician communication binder) revealed an entry dated 10/19/21 for Resident #2, "Behavior seems normal but resident appears pale and weak". The entry was signed by Nurse Practitioner (NP#1) for the resident's primary physician on 10/22/21. There was also an entry dated 10/26/21 for Resident #2 which indicated "weak, pale, eyes sunken." This entry was crossed out with a note indicating that the resident had been transferred to the hospital on 10/27/21.

Record review of the Physician Orders for October 2021 for Resident #2 revealed orders for "NPO"(Nothing by Mouth) dated 4/05/21. Send resident to (Proper Name of Local Hospital) for evaluation related to respiratory distress and temperature 100.8 dated 10/27/21 at 3:05 AM. There were no Physician Orders for water flushes included in the Physician Orders.

Record review of the "History and Physical" from the hospital admission for Resident #2 dated 10/27/21 revealed Resident #2 was admitted to the hospital with admitting diagnosis of 'Shock ...Most likely multifactorial, could be septic and hypovolemic... Active Problems included "Acute kidney injury, Hypernatremia, Hyperchloremia". The hospital records indicated Resident #2 was "nonresponsive, tachypneic ...intubated and given 1 Liter of Normal Saline. Shortly after patient had

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a brief PEA (Pulseless Electrical Activity) arrest ...with ROSC (return of spontaneous circulation) after one round of compressions. Labs were significant ... Sodium (Na+) greater than 180, Chloride greater than 140, Blood Urea Nitrogen (BUN) 187, Cr (Creatinine) 3.23"...Physical Exam ...General: ill appearing, poorly cared for elderly male ...The Assessment and Plan section of the hospital record revealed the diagnosis of "Shock" was treated as "most likely multifactorial, could be septic and hypovolemic ...Status post (S/P) aggressive fluid resuscitation ...lactate slightly improved with fluids". "Hyperchloremic Hypernatremia Na greater than 180, chloride greater than 140. Patient PEG tube dependent. Lactic acid 8.-obvious lack of free water, most likely due to lack of FWF (Free Water Flushes) administration for prolonged period of time ...fluid resuscitated with isotonic fluids initially, now will start D5w 125 ml/hr (milliliters per hour) ...difficult to establish goal as current value too high to record". "Acute renal failure Bs (base line) Cr (Creatinine) 0.6, last value recorded from April. Cr on admission 3.23, BUN 187. UA very concentrated specific gravity 1.034 ...-received isotonic fluid resuscitation-Foley (catheter) placed from strict I's and O's (intake and outputs)-will monitor closely ...Disposition: continue to manage shock and correct hypernatremia". Resident #2 was admitted for inpatient care at 8:01 on 10/27/21.

Record review of Departmental Notes dated 9/16/21 at 2:14 PM of the "Role: Nursing: notes revealed, " ...He receives all nutritional support and hydration via peg tube ...". The entry was signed by Licensed Practical Nurse (LPN #1)

Record review of Departmental Notes dated 10/27/21 at 3:00 AM of the "Role: Nursing"

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revealed, "2:40 AM upon entering room, resident appeared to have respiratory distress. Unresponsive. BP (blood pressure) 89/59, T (temperature) 100.8, R (respiration rate) 28, P (pulse) 125. Fingers appear swollen. Top of mouth is discolored and dry... 2:45 AM. (Formal Name of MD #1) notified of resident condition and N.O. (new order) send resident to (hospital) for evaluation ..."

0n 11/02/21 at 3:40 PM, an interview with the Director of Nurses (DON) revealed when asked how do you monitor the resident's fluid intake, including enteral feeding if applicable, the DON responded "Follow physicians orders. Actual measurement is usually documented on the MAR". When asked what potential hydration deficits has the resident experienced, the DON states she is not aware and doesn't know. When asked what other limitations or factors impact the resident's hydration, the DON responded, "Medications is the only thing I know of". When asked how do you ensure the resident is provided with adequate fluids, the DON stated, "Physician orders and physician ordered lab work to be quantitative". When asked what, when, and to whom do you report changes in fluid intake, the DON responded, "The floor nurse reports it to the physician". The DON explained the Registered Dietician makes recommendations in writing, which are presented to the physician and if approved by the physician they are entered into the resident's record as an order by the Unit Manager or nurse. The DON stated if the physician orders based on the Registered Dieticians recommendations appeared differently on the physicians orders and Medication Administration Record (MAR), then it was considered a transcription error by the Unit Manager or nurse. The DON acknowledged

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Resident #2 received a hypertonic tube feeding and did not receive free water flushes for forty-three (43) days.

On 11/02/21 at 2:24 PM, an interview with LPN #4, charge nurse revealed she stated "Somedays I am the Unit Manager for the second floor. I transcribed what was on the paper as far as the flushes." She could not explain why the 175 cc free water flushes listed on the 'Nutrition Recommendation' sheet was not on the physician orders or MAR.

On 11/03/21 at 1:10 PM, an interview with RD #2 revealed she started work at the facility on 9/20/21. She stated RD #1 no longer worked at the facility. RD #2 stated Registered Dieticians use a clinical formula which involved residents' weight, height, diagnosis, and medications along with other factors to determine the appropriate amount for free water flushes for each resident with a feeding tube. She confirmed Resident #2 needed the free water flushes and stated the Glucerna 1.5 tube feeding would not have provided sufficient amount of water on its own. She stated she had not been notified that Resident #2 had any signs or symptoms of dehydration by the staff.

On 11/03/21 at 4:10 PM, an interview with the physician for Resident #2, MD #1, revealed he was familiar with the resident and his care. He stated he had been called on the evening of 10/26/21 and notified of signs and symptoms of level of consciousness change, elevated temperature and tachypnea for Resident #2 and had issued an order to send Resident #2 to the hospital for evaluation. MD #1 stated he was not aware Resident #2 was not receiving water flushes via his peg tube. MD #1 stated he had

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been apprized by the RD of the new dietary recommendations and agreed to the recommended changes without modification. MD #1 stated after he had issued new orders based on the RD recommendations, "they would be sent to nursing for the order to be transcribed". When asked how much he felt the lack of water had contributed to the hospitalization of Resident #2, MD #1 responded "It would be nice to be able to say it would have a neutral effect, but I cannot deny it would have had a significant effect".

REMOVAL PLAN
11/3/21

Manhattan Nursing and Rehabilitation

Removal Plan - IJ - Residents with tube feeding formula, water flushes, care plans

The facility was informed by state agency 11/3/21 3:30pm of an immediate jeopardy and substandard quality of care. The state agency provided the facility with IJ templates for F692, F693, F656.

The facility failed to transcribe the dietary registered dietitian recommendations correctly resulting in omission of free water flushes for resident number two.

The facility failed to provide resident # 2 sufficient fluid intake to maintain proper hydration and health by failing to transcribe the dietary recommendations correctly resulting in omission of free water flushes from 9/14/21 through 10/27/21 when resident was admitted to hospital for hypovolemic shock.

The facility failed to fully develop and implement a

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comprehensive care plan for resident # 2 as 10/6/21 care plan states "resident receives medication and hydration". Goal states "will show no signs and symptoms fluid volume deficit through1/2022" but had no approach for free water flushes as recommended by registered dietitian; with order start date of 9/14/21 to provide total free water of 2144cc.

Corrective actions:

1. On 11/3/21 at 10:00a.m. 100% audits sixteen of sixteen residents with enteral feedings and water flushes were initiated and completed on 11/04/2021 at 10:00am. to ensure accuracy of physician orders with documentation of enteral feeding and water flushes on the medication administration record (MAR). The audits were completed by supervisory registered nurses. There are 16 residents with feeding tubes in the facility on 11/4/21. Zero of 16 residents needed revision and/or corrections.

2. On 11/3/21 at 2:30pm licensed nurses and certified nursing assistants were in-serviced by supervisory registered nurses related to signs and symptoms of dehydration, residents with enteral feeding, orders for enteral formula, water flushes, documentation of enteral formula and water flushes on the medication administration record(MAR) with the plan of care reviewed/revised as indicated, and that residents are receiving enteral feedings as physician ordered and recommended amount of feedings and flushes to equal the daily ordered and recommended amounts. Licensed nurses and certified nursing assistants will not be allowed to work until they have been in-serviced.

3. On 11/4/21 at 12:00pm the sixteen residents

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with enteral feeding/water flushes plan of care have been reviewed by the Director of Nursing and MDS Coordinator. No revision was needed. and was completed 11/4/21 at 12:00pm related to residents enteral feeding physician ordered formula and water flushes.

4. On 11/3/21 at 3:45 pm. the Quality Assurance (QA) committee met to include Executive Director, Director of Nurses (also Infection Preventionist at present), Regional Clinical Operation nurse, Vice President of Operations, and Medical Director in regard to Immediate Jeopardy cited for failure to provide sufficient fluid intake, failure to provide resident enteral feeding as physician ordered, and failure to develop and implement a comprehensive person centered care plan to meet the resident needs. Corrective actions will ensure that residents are receiving enteral feedings per physician orders and recommended amount of feeding and flushes to equal the daily ordered and recommended amounts. Two (2) policies were reviewed- (1. Tube Feeding and 2. Care plan policy. No revisions were made to the policies. QA Committee decided to implement collection of registered dietitian recommendations upon completion by nursing staff per physician orders and will be retained by medical records for a minimum of one year. Director of Nursing Services/RN supervisory nurses will complete an enteral feeding audit on all residents with enteral feedings physician orders for formula and water flushes to ensure accuracy and documentation of enteral feeding and water flushes on the medication administration record daily.

5. On 11/3/21 at 3:30pm all sixteen residents (16) residents with enteral feedings were assessed for signs and symptoms of dehydration by supervisor

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	25MA	A. BUILDING: _____ B. WING _____	C 11/05/2021

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registered nurses, completed 11/04/2021 at 10:00am with no residents found with concerns of dehydration. Dehydration risk assessments have been reviewed, updated, and completed on each resident with enteral feedings by supervisory registered nurses on 11/4/21 at 12:00pm.

6. On 11/3/21 at 8:00pm the Director of Nursing audited enteral feedings and evaluated sixteen (16) residents who are receiving enteral feeding per physician orders and recommended amount of feeding and flushes to equal the daily ordered and RD recommended amounts and verifying sufficient fluid intake approaches are on the person-centered comprehensive care plan.

7. Facility alleges relieving the immediacy of this immediate jeopardy on 11/4/21 at 2:00pm.

On 11/05/2021 SA entered facility for verification of Removal Plan for Immediate Jeopardy.

Validation:

1. On 11/05/2021 interview with director of nursing indicated audits were completed for all residents who resided in the facility which ensured accuracy of physician orders with documentation of enteral feedings and water flushes. SA validated through interview and record reviews for Residents #2, #3, #4, and #5 (along with all the other residents in facility on this date with feeding tubes) accuracy of feeding tube orders with water flushes on medication administration records with no revisions or corrections necessary.

2. On 11/05/2021 through interviews with Director of Nursing and Acting Director of

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M 650	Continued From page 25 Nursing, and record review of facility "Educational In-Service Record" titled Tube Feedings / Care Plans / S/S Dehydration / Transcription of Tube Feeding Orders / Free Water Flushes for tube feeders" sign-in sheet, the SA validated that in-service was conducted for all nurses and certified nursing assistants related to signs and symptoms of dehydration, residents with enteral feedings, orders for enteral formula, water flushes, documentation of enteral feedings and flushes on the medication administration record with the plan of care reviewed/revised as indicated, and that residents are receiving enteral feedings and flushes as ordered by physician and recommended by the dietician to equal the daily ordered and recommended amounts. Through interviews with LPN #3, LPN #5, LPN #6, and CNA # 2 and CNA #3, SA validated that nursing staff was not allowed to work until they had been properly in-serviced. 3. On 11/05/2021 SA validated through interview with Director of Nursing that care plans of Residents #2, #3, #4, and #5 (and the other residents in facility on this date with feeding tubes) were reviewed related to residents' enteral feedings and water flushes as physician ordered and dietary recommendations. Record review of residents #2, #3, #4, and #5 (and the other residents in facility on this date with feeding tubes) care plans indicate enteral feeding orders, flush orders, and observation for signs and symptoms of dehydration. 4. On 11/05/2021 through interviews with four (4) members of the Quality Assurance committee including the Director of Nursing (also the Infection Preventionist), the Acting Director of Nursing, the Administrator and the Registered Dietician and record review of facility "Monthly	M 650		

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Facility QA & A Minutes" sign-in sheet dated 11/03/2021 at 3:45pm; the SA validated a meeting of the QA & A committee regarding the Immediate Jeopardy for failure to provide sufficient fluid intake, failure to provide residents enteral feedings as physician ordered, and failure to fully develop and implement a comprehensive, person-centered care plan to meet the resident needs. Two (2) policies were reviewed: 1) Tube feeding Policy and 2) Care Plan Policy. No revisions were formulated to the policies. The committee did, however, decide to implement collection of Registered Dietician recommendations upon completion by nursing staff per physician orders and will be retained by Medical Records for a minimum of one (1) year. Also added will be an enteral feeding audit daily on all residents with enteral feedings and water flushes by Director of Nursing and RN supervisory nurses to ensure accuracy and documentation of enteral feedings and water flushes on the medication administration record.

5. On 11/05/2021 through interview with Director of Nursing and record review of facility "Evaluation of Dehydration Risk" assessment forms for Residents #2, #3, #4, and #5, (and the other residents in facility on this date with feeding tubes) dated 11/04/2021, and observation of Residents #2, #3, #4, and #5 for signs and symptoms of dehydration, SA validated that 100% of residents in facility with feeding tubes were assessed for signs and symptoms of dehydration with no resident found with signs or symptoms of dehydration.

6. On 11/05/2021 through interview with Director of Nursing and record review of facility "Physician Orders", facility "Department Notes - Category - Dietary", and facility "Daily Care Guide", SA

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M 650	Continued From page 27 validated 100% of residents requiring tube feedings are receiving enteral feedings and water flushes per Physician orders per Registered Dietician recommendations and are verifying sufficient fluid intake approaches on the person-centered comprehensive plan of care. 7. The SA validated on 11/05/2021 all corrective actions were completed as of 11/04/2021 and Immediate Jeopardy was removed on 11/04/2021 prior to exit.	M 650		