STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BISHOP REHABILITATION AND NURSING CENTER	918 JAMES STREET SYRACUSE, NY 13203

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** Based on observation, interview, and record review during the abbreviated survey (NY 570), the facility did not ensure each resident who is unable to carry out activities of daily living (ADL) received the necessary services to maintain good personal and oral hygiene for 1 of 7 residents reviewed for quality of care. Specifically, Resident #7's oral/dental health was not routinely monitored and there was no evidence the resident was routinely assisted with oral care by facility staff. Findings include: The facility's 12/2017 Routine Dental Care policy documented each resident would receive routine dental care and the nursing staff would conduct ongoing oral health assessments to assure each resident received adequate oral hygiene. Resident #7 was admitted to the facility with [DIAGNOSES REDACTED]. The 11/30/19 Minimum Data Set (MDS) assessment documented the resident had severely impaired cognition and required extensive assistance for all activities of daily living (ADLs). The 3/20/18 comprehensive care plan (CCP) documented the resident had an ADL self-care deficit. The resident's oral hygiene needs were not documented on the CCP. An initial dental exam dated 4/12/2018 documented the resident had multiple broken and fractured teeth on the top and capped teeth on the bottom. The exam documented tooth #9 was broken and tooth #23 was present. A dental consult dated 9/6/2018 documented the resident was seen for mouth pain. All teeth were checked, and no swelling or abscesses were noted. A dental note dated 3/16/2019 documented the resident was seen for an annual exam and the condition of the teeth were unchanged. A dental progress note dated 1/9/2020 documented the resident had a few worn-down teeth and some stainless-steel crowns. There was no swelling or infection, and the resident's oral health was not good. Tooth #9 was documented as broken and missing. No other teeth were documented as missing. A social worker's progress note dated 1/24/2020 documented the team discussed dental concerns identified by the resident's family member. Dental records were presented to the family member that was present at the meeting. The Kardex (care instructions) dated 2/22/2020 did not include instructions for staff on providing oral care to the resident. On 2/22/2020 at 8:45 AM, licensed practical nurse (LPN) #20 showed the surveyor the resident's mouth. She stated the resident's family member expressed concern that someone pulled out two of the resident's teeth. The resident was missing tooth #9 (top front) and #23 (bottom front). The rest of the resident's teeth were broken, discolored, or capped with stainless steel caps. LPN #20 stated the resident was always missing the right front top tooth. She stated when she talked with the family member, they were concerned with the back-right side teeth. The resident was observed on 2/22/2020 at 11:30 AM, lying in bed with the family member at the bedside. The family member stated she contacted someone at the facility regarding the resident's missing teeth. She came in everyday and brushed the resident's teeth and one day in 1/2020, she noticed the resident had two missing teeth. The family member pointed out the missing teeth, tooth #9 and tooth #23. During a follow-up interview with the family member on 2/23/2020 at 11:20 AM, she stated she spoke with the social worker about the resident's missing teeth and the social worker told her that the resident's teeth had fallen out. During an interview with Dentist #13 on 2/27/2020 at 3:00 PM, she stated in 1/2020 she was notified the resident's family member felt that someone removed a couple of the resident's teeth. She was asked to examine the resident at that time and she completed a new tooth chart. The dentist stated her exams included the following: - An initial examination on 4/18/2018. During that exam, tooth #9 was worn down but present. - On 3/16/2019, there were no changes from the initial exam done on 4/18/2018. - On 1/9/2020, tooth #9 was present but was worn down and broken. Tooth #23 was also present at that time. The dentist showed the surveyor the resident's teeth. The dentist stated tooth #23 was present but there was a large space between the teeth making it appear that it was not there. The dentist stated she did not know what happened to tooth #9 as it was present on 1/9/2020 and was not present on the day of the interview/observations. She stated she expected oral care be done on residents at least twice daily and she expected to be notified of any missing or broken teeth. During an interview with certified nurse aide (CNA) #14 on 2/27/2020 at 3:30 PM, he stated he was the liaison for the dentist and was notified if a resident had dental issues or needed to be seen by the dentist. The first time he was notified of dental issues with the resident was in 1/2020. During an interview with registered nurse (RN) Manager #11 on 2/27/2020 at 4:20 PM, she stated oral care was done by the CNAs and the frequency was documented on the Kardex and individualized for each resident. If a resident had any issues with their teeth, missing or broken, the CNA should notify the nurse and they would evaluate and notify the physician, nurse practitioner (NP) or dentist. She was not aware of Resident #7 having any issues with teeth until she was told the resident's family member was concerned that someone had come in and pulled out the resident's teeth. She had not assessed the resident's mouth but was aware the dentist had done an exam and the social worker had met with the family. During an interview with CNA #15 on 2/27/2020 at 4:55 PM, she stated the Kardex or care instructions documented how often teeth should be cleaned. She stated when she cared for the resident, she used toothettes in the resident's mouth. She stated she never noticed any broken or missing teeth and if she had, she would have reported it the nurse. During an interview with social worker #16 on 2/27/2020 at 5:30 PM, she stated she was notified by staff that the resident's family member expressed concern regarding the condition of the resident's teeth and insisted that someone removed some of the resident's teeth. She met with the family member in the presence of the dentist and showed the family that there were no changes in the condition of the resident's teeth since admission. The family member continued to insist the resident had missing teeth. 10NYCRR 415.12(a)(3)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **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 observation, interview, and record review during the abbreviated surveys (NY 169 and NY 511), the facility did not ensure the resident environment remained free of accident hazards and adequate supervision and assistance devices were provided to prevent accidents for 1 of 3 residents (Resident #8) reviewed for accidents. Specifically, Resident #8: - was not thoroughly assessed for wandering upon admission; - was sent on an appointment without supervision, wandered from the appointment unnoticed and was missing for 12-hours before being found; - was not reassessed timely for wandering when he returned to the facility; - did not have a wanderguard applied timely when he was re-assessed and deemed to be at high risk to wander. Findings include: The facility's revised 5/2018 Missing Resident Policy documents upon identification that the staff are unable to quickly account for a resident's whereabouts, the following procedure will be implemented. Nursing unit will immediately announce Code Yellow, the unit, and the resident's full name over the public address system. Nursing Supervisor to report to the unit. each department, every area of the building and surrounding grounds will be searched. Code Yellow will be paged every 5 minutes until the resident is found. Once found, Code Yellow will be cleared. An incident

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

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.

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) report will be generated by the affected unit's nursing staff and a full investigation will be conducted. The undated Wandering Behavior Management Policy documents residents assessed as having a potential for unsafe wandering and/or elopement will be observed for the following: exit seeking, packing suitcase, visual monitoring of exits or elevators. Staff will document observations in the medical record and in the Wander Risk Assessment form. The care plan will be adjusted as appropriate based on assessment and with family input to address causative factors. The residents will have their picture taken, stored in the EMR (electronic medical record) and placed at the reception desk. Resident #8 had [DIAGNOSES REDACTED]. The 4/15/19 Minimum Data Set (MDS) assessment documented the resident had moderate cognitive impairment, did not wander, required limited assistance with locomotion, and did not have a wanderguard. The 4/8/19 Admissions Assessment completed by Assistant Director of Nursing (ADON) #31, documented the resident was admitted after a stroke, was walking around the room independently and the resident's gait was unsteady. The resident was alert and oriented with intermittent switching of dates and short-term memory problems. The 4/8/19 Wandering Risk Score completed by ADON #31 documented the resident scored a 1 or was at low risk to wander. The assessment was incomplete and did not include answers to the questions referencing a dementia diagnosis, history of wandering, and mobility status. The 4/9/19 comprehensive care plan (CCP) documented the resident was at high risk to fall due to gait/balance issues and had an activities of daily living (ADL) deficit. Interventions included not to leave unattended in diagnostic or treatment areas and provide supervision by 1 staff to move between surfaces with walker at all times. The CCP did not document the resident was at risk to wander. The 5/8/19 physician's progress note documented the resident was alert with some cognitive frailty, could make needs known, was on [MEDICAL CONDITION] precautions and required extensive assistance for personal care. The 6/18/19 at 10:37 PM nursing note documented she was notified by the floor nurse the resident left at 8 AM for an appointment and had not returned to the facility. Local hospitals were called and the resident had not been admitted . The company that transported the resident to the appointment was called and was closed. The resident's family was called and made aware of the situation and the family stated they did not go to the appointment with the resident. A Code Yellow (missing resident code) was activated and all floors of the facility were searched. The 6/18/19 facility investigation documented the resident did not return from an appointment and this was noticed by the licensed practical nurse (LPN) attempting to pass meds at 8:05 PM. The resident normally spent time off of the unit so facility staff did not find it unusual when he was not on the unit that day. At 9 PM, a Code Yellow was called. The resident's family reported they called the resident's cell phone and they picked the resident up at 10:05 PM. The resident reported waiting for hours to be picked up by transport and then decided to walk home. A statement attached to the incident report from social worker #32 documented she spoke on the phone with the resident's family member on 6/17/19 and it was reported to her the family member could not attend the resident's appointment on 6/18/19 with the resident and she wanted to be sure the resident still went on the appointment. Social worker #32 informed the family member the appointment and transportation were arranged. The was no documented evidence the resident was reassessed for wandering risk upon returning to the facility on [DATE]. The 6/24/19 physician order [REDACTED]. The 7/10/19 at 3:43 PM social worker's progress note documented the resident's family member wanted the facility to consider a wanderguard for the resident and the Nurse Manager would follow up. The 7/10/19 Quarterly Wandering Risk Scale completed by RN Manager #26 documented the resident was at high risk to wander. There was no documented evidence in the record a wanderguard was ordered for the resident at that time. The 7/12/19 at 4:32 PM LPN #39 note documented the resident was found on the first floor (different level than resident's unit) by the first-floor Nurse Manager and was brought back to the resident's floor safely. The 7/12/19 at 11:40 PM LPN #39 note documented the Supervisor was alerted the resident did not have a wanderguard on. The 7/18/19 at 12:24 PM nursing progress note documented the resident was sent to the hospital for acute mental status change. The 7/22/19 readmission Wander Risk Scale documented the resident was at high risk to wander. The 7/22/19 physician order [REDACTED]. Unsafe wander precautions, check wander guard bracelet every shift. The 7/22/19 CCP documented the resident was at high risk to wander related to being disoriented to place, impaired safety awareness and the resident wandered aimlessly. Interventions included to use wanderguard and check placement of wanderguard every shift, distract from wandering, observe for wandering into unsupervised areas and redirect away and a photo was to be placed in the Roam Alert system. On 1/21/20 at 10:42 AM, the resident's family member stated in an interview the resident had dementia and prior to admission, would wander the house but never got out. The family member stated she would never leave the resident alone. She stated she discussed the resident's wandering with facility staff upon admission. She stated the facility sending the resident on an appointment alone was not acceptable. The day before the resident's appointment on 6/18/19, she called and spoke to SW #32 to let her know she would not be available to go, and SW #32 assured her they would take care of it. She assumed a CNA would accompany the resident on the appointment. On 6/18/19 she received a call from the facility in the evening, it was almost dark, and was told the resident had not returned from the appointment. She called the resident's phone 3 times before the resident answered. The resident told her they were on a road and on the way back to New York City. The resident had no idea where they were. She instructed the resident to look at a street sign or a name on the building and that was how she found the resident. When she arrived the resident was cold, hungry and wet from urine. She stated prior to the 6/18/19 incident she requested a wanderguard and the facility told her it was against the law to apply one. She received another call sometime after 6/18/19 when the resident was again found missing from the unit and was later told the was found in the building. At that time, staff asked her if it was okay to apply a wanderguard. She stated to them she had been asking for one all along and why now was it okay to apply one? She stated the resident had another instance where the resident was able to get off the unit with a wanderguard in place. On 1/21/20 at 1:33 PM, patient liaison #36 stated in an interview she was responsible for arranging appointments for residents. She stated the resident could not go on appointments alone and was always accompanied by a family member. The family member would let her know if she could not attend an appointment and she would arrange for a CNA to go with the resident. She stated she was not aware SW #32 knew the day before the appointment the family member could not go on the appointment. Her shift ended at 2:30 PM every day and she recalled on 6/18/19 talking with other CNAs that the resident had not yet returned from the appointment. She did not mention it to the Nurse Manager. She stated on 6/18/19, she was not on the floor when the transport company came for the resident and all staff should have known the resident had to go with someone. Staff should have questioned the resident leaving alone. On 1/21/20 at 2 PM, ADON #31 stated in an interview Wander Scale assessments were done on admission and determined a resident's risk based on the questions answered. The whole page of questions should be answered to determine risk and she was not sure why all the questions were not answered on the resident's assessment she had completed. She stated based on the resident's assessment, if all the questions were answered the resident should have scored at risk for wandering. Residents assessed at risk of wandering would automatically have a wanderguard placed. Interventions would then be care planned and would include a wanderguard and the need to have a CNA or family go on appointments. The RN Manager would let the patient liaison know who could and could not go on appointments by themselves. On 1/21/20 at 3:35 PM, RN #26 Manager stated in an interview Wandering assessments were done on admission. There was a scoring system and all questions needed to be answered to determine risk. When someone was at risk of wandering interventions were put in place. The intervention may not necessarily be a wanderguard. Other interventions could include increasing activities to keep the resident busy, increased supervision, or maybe move their room closer to the nursing station. The IDT determined if residents could go on appointments alone and would look at cognition and ambulation status, and whether the resident could make their own decisions. She recalled the incident with the resident on 6/18/19 but had left her shift around 3 PM. After an event like a wandering assessment should be completed. She did not recall if one was done or not. When the resident went on appointments, the resident was able to ambulate independently and sometimes the family member went in the van or she would meet the resident there. She was not aware the family member could not go on the appointment on 6/18/19. She stated it was an isolated event and the resident did not show exit seeking behavior. She would not consider the 6/18/19 incident an elopement. She stated the resident ended up getting a wanderguard later when active exit seeking began. On 7/10, she completed a wander assessment after the resident's family member requested a wanderguard and the resident scored at high risk. She normally notified the physician for an order, updated the care plan and placed the wanderguard on the resident. On 7/12/19, when the resident was found without his wanderguard he may have taken it off. If she placed the wanderguard on the resident on 7/10, he would have had an order and the CP would be updated. The resident did not have orders or a care plan for wandering until readmission after a hospital stay from 7/18 through 7/21/19. Code Yellow meant a resident was missing and she was not sure if an incident report should have been completed when the resident was missing in August and found near the front door. On 1/21/20 at 4:17 PM, SW #32 stated in an interview she remembered when the resident's family member called to say she would not be at the resident's appointment on 6/18/19. She did not think anything of it because she always saw the resident outside taking walks and sitting on the bench and believed the was signing themself out for

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F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) these walks. She did not recall the resident's cognition at the time of the incident and usually the RN determined if a resident could go on appointments alone. 10NYCRR 415.12(h)(1)
F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview during an abbreviated survey (NY 018) the facility did not ensure a resident who is fed by enteral means (receives nutrition through a tube placed in the gastrointestinal tract) receives the appropriate treatment and services to prevent complications of enteral feeding for 1 of 7 residents (Resident #6) reviewed for quality of care. Specifically, Resident #6's feeding tube had multiple malfunctions including clogging and dislodgement and the plan of care was not followed to prevent these complications. The resident was sent to the hospital on multiple occasions for tube replacement. Additionally, the resident received clysis (fluid replacement under the skin) multiple times in place of nutritional support from the tube feeding while the feeding tube was dislodged. Findings include: The facility's Tube Feedings policy, effective 7/2018 and revised 9/2019, documents feedings may be held for showers, ADLs (activities of daily living) and when a resident goes out on pass. For [DEVICE] (gastrostomy, feeding tube is placed in the stomach) feeding, check placement, if concerns arise regarding placement or dislodgement, notify the physician and obtain X-ray confirmation. For J-tube (a feeding tube place in the small intestine, jejunum), tube placement is not checked. Note any unusual drainage of feed around the tube site or unusual firmness of abdomen that may indicate displacement of the tube. Resident #6 was admitted to the facility with [DIAGNOSES REDACTED]. The 6/2/19 Minimum Data Set (MDS) documented the resident had severe cognitive impairment, was dependent on staff for all ADLs, had functional limitation on one side of the body, and had a feeding tube. The comprehensive care plan (CCP) dated 10/9/2018 documented the resident required a tube feeding as a sole means of nutrition and hydration secondary to dysphagia with a goal of maintaining adequate nutritional and hydration status. Interventions included head of bed elevated and obtain and monitor labs, check skin integrity every shift, monitor/document/report any signs and symptoms of tube dislodgement. The undated Kardex (care instructions) documented abdominal binder in place, check skin integrity every shift. A registered dietitian (RD) assessment dated [DATE] documented the resident's estimated daily nutrient needs were 1912-2162 calories, 74 grams (g) of protein, and 1912 cubic centimeters (cc) of fluid. Nursing progress notes from 4/1/19-2/28/20 documented the resident had the G/J tube replaced at [MEDICATION NAME] Radiology (IR) 20 times. A physician order [REDACTED]. Clysis was ordered when the G/J tube was malfunctioning or displaced. A physician order [REDACTED]. Manually flushed in tube as needed for clogged tube every 48 hours. Nursing progress notes and medication administration records (MARs) documented the [MEDICATION NAME] crushed in warm water with sodium [MEDICATION NAME] for a clogged G/J tube was administered on 4/30/2019 and 2/18/2020. There was no documentation the [MEDICATION NAME] was administered at other times. On 9/9/2019 the physician documented the resident's J-tube portion of the tube was clogged and questioned whether the resident really needed the J-tube portion of the tube and perhaps simply replace the J-tube. CLOGGED FEEDING TUBE The active (current) physician order [REDACTED]. Administer 80 cubic centimeters (cc) of extra fluid via [DEVICE] and 80 cc of extra fluid in J-tube every 4 hours. Resident #6 was observed on 2/23/2020 at 8:50 AM lying in bed. The tube feeding was not running and was not connected to the G/J tube. The resident was not wearing an abdominal binder and his blanket was drawn back enough to observe the G/J tube. The adaptor at the end of the feeding pump tubing had a drop of tube feeding that appeared congealed. No one entered the resident's room until the ADON (Assistant Director of Nursing) entered at 9:15 AM. The ADON came back out to the hallway and stated he was just checking on the resident. At 9:18 AM, the resident was again observed unhooked from the tube feeding and had no abdominal binder in place. During an observation on 2/23/2020 at 9:25 AM LPN #22 entered the resident's room and stated it was time for the water flush. She stated she had not been in to see the resident yet this morning. She was a float LPN but was familiar with the resident. She cleansed around the G/J tube and applied a new split sponge. She hung a new formula bottle and new tubing. The LPN administered a flush and [MEDICATION NAME] (medication for [MEDICAL CONDITION] reflux, GERD) through the G tube. She then attempted to flush the J-tube by gravity and was not able to. She then attached the plunger to the syringe and was still unable to push the water through the J-tube. For 4 minutes, the LPN attempted to push the water through the J-tube with the plunger with no success. The LPN stated she did not know why the resident's tube feeding was not hooked up and running. She stated she was in to check on the resident around 7:15 AM after report and the tube feeding was running at that time without any issues. CNAs were not allowed to unhook the resident's tube feeding and she did not know who would have unhooked it and was not notified that it had been disconnected or that there was an issue with it. She knew the resident's tube was frequently clogged and the resident had to be sent out to have it changed. The LPN went out to her medication cart and put 15-30 ml of warm water in a medicine cup and dissolved [MEDICATION NAME] and sodium [MEDICATION NAME] tablet in the water. She went into the resident's room and spent several minutes trying to push the liquid in the resident's tube. She was able to administer about 10 ml of the liquid in the tube. The LPN left the room and stated she was going down to the first floor to see what the ADON wanted her to do. On 2/23/2020 at 10:40 AM, LPN #22 returned to the resident's room with the ADON. The ADON stated the [MEDICATION NAME] was not effective and he instructed the LPN to connect the tubing and administer the tube feeding through the [DEVICE] until the tube could be changed. The ADON stated when he went into the resident's room earlier, he noticed that the tube feeding was not running so he went to check the orders and noticed that it should be running, so he told the LPN to address it. LPN #22 flushed the [DEVICE] and connected the tube feeding to the [DEVICE]. A nursing progress note dated 2/23/2020 at 10:56 AM, documented the residents J-tube was clogged and unable to be unclogged with ordered medications. Telehealth was contacted and orders were obtained to change 80 ml flush every 4 hours to [DEVICE] for a total of 160 ml of free water every 4 hours and it was okay to utilize the [DEVICE] for all medications/flushes/tube feeds until the J-tube could be evaluated by IR. ABDOMINAL BINDER Nursing progress notes documented the resident had pulled his G/J tube out on 5/4/2019 and on 6/18/2019. A written note, dated 7/1/2019, from the Unit Manager of the hospital's [MEDICATION NAME] Radiology Department (IR) documented Resident #6 continued to return to the hospital for G/J tube complications without any clear plan for prevention. The IR department was extremely concerned as this was an ongoing issue and they would like a plan put in place to prevent this. The tube needed to be positioned by using perhaps an abdominal binder to protect the tube. Nursing progress notes documented the resident had pulled out the G/J tube on 7/13/2019 and was sent to the hospital to have it replaced. A revision to the CCP dated 8/6/2019 documented an abdominal binder was put in place and skin integrity was to be checked every shift. Nursing progress notes documented the resident pulled out his G/J tube on 8/10/2019, 9/24/2019, 12/8/2019 and 12/17/2019 and was sent to the hospital to have the tube replaced. A nursing progress note dated 12/14/2019 documented the resident had pulled out the tube and the tube had a slit in it. The resident was observed on 2/22/2020 at 10:10 AM, 2/23/2020 at 8:50 AM and on 2/27/2020 at 3:40 PM, without an abdominal binder in place. TEAR IN TUBING A nursing progress note dated 11/9/2019 documented he was notified regarding complications with the resident's G/J tube and an assessment revealed a small crack in the J-tube. No complications were observed with the [DEVICE]. Preexisting orders were in place to use the [DEVICE] for feeding, flushes and medications if the J-tube was nonfunctional/clogged. The floor nurse was educated and instructed on how to cover the cracked area to prevent inadvertent backflow of stomach contents. A nursing progress note dated 11/26/2019 documented a care plan meeting was held for the resident and the resident had no acute issues at that time. A nursing progress note dated 11/28/2019 at 5:22 AM documented the nurse was made aware of problems with the resident's J-tube. The tube feeding was leaking where there was a split in the tube. An occlusive [MEDICATION NAME] (clear/translucent dressing) was placed on the leak and the resident continued with the tube feeding. The unit nurse called back and reported there were gastric like secretions coming from the J-tube. The nurse was instructed to wrap a chux (absorbent cloth) around the tube to prevent the gastric secretions from contacting the resident's skin. The resident had previous problems with the [DEVICE] and the crack was at the juncture of the G and the J tube. The physician would be notified in the AM as this was not an emergent issue. A nursing progress note dated 11/28/2019 at 6:27 AM documented the Supervisor was called as there were stomach contents leaking from the resident's tube. The Supervisor assessed and applied [MEDICATION NAME]. At 4:00 AM it was noted that the [MEDICATION NAME] was not working. A progress note dated 11/30/2019 documented the resident had recently returned from the hospital, within the past 24 hours, from having the G/J tube replaced. INTERVIEWS On 2/23/2020 at 10:15 AM CNA #23 was interviewed and stated CNAs were not allowed to disconnect tube feedings and when they had to provide care, they would have the LPN disconnect it. Her shift started at 7:00 AM that day and she attended morning report and did not recall any issues brought up about Resident #6. She had not yet been in Resident #6's room and did not know how the tube feeding had become

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0693 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) disconnected. The resident pulled the tube out frequently and the nurses sometimes could not get the tube to flush. The resident went out to the hospital to have it changed a lot. The resident was supposed to be wearing an abdominal binder but they did not use it because the resident would also frequently remove it and it did not work. On 2/23/2020 at 10:25 AM CNA # 24 stated the CNAs were not allowed to touch Resident #6's tube feeding. She had not yet been in the resident's room to provide care and did not know how the tube feeding was disconnected. During an interview on 2/23/2020 at 12:35 PM LPN #25 stated she had worked the night shift last night and had taken care of Resident #6. She stated she put the tube feeding through the J-tube instead of the [DEVICE]. She knew the orders stated the feeding was supposed to go through the [DEVICE], but she had just followed what was in place when she took over the resident's care and that was his feeding was going through the J-tube. She had given the resident medication through the J-tube and the flush around 5:30 AM and she had reconnected the feeding. During an interview with the Director of Nursing (DON) on 2/23/2020 at 1:20 PM he stated the resident's tube feeding orders were to administer medications and tube feeding through the [DEVICE]. The resident had a G/J tube and the J-tube was used when the resident was first admitted to the facility because of frequent aspiration (tube feeding formula gets into the lungs). As the resident became more stable everything was going through the [DEVICE] and only flushes were supposed to go through J-tube to maintain patency. During an interview with RN Manager #26 on 2/27/2020 at 3:50 PM, she stated Resident #6 had a G/J tube in place. The resident frequently aspirated when first admitted and lately that had gotten better. The resident frequently went to the hospital IR to have the G/J tube changed because it either became clogged or had been pulled out. The plan to prevent the resident from pulling the tube out was an abdominal binder which was supposed to be in place at all times. The resident was care planned to have skin checked underneath the binder every shift. She reviewed all IR documentation upon the resident's return and was aware that IR had recommended the abdominal binder. She did not know why the recommendation was not put into place until a few weeks later. She did not remember what the plan was to prevent the resident from pulling out the tube prior to that. To prevent clogging of the tube they use to have automatic flushes but when they got new feeding pumps automatic flushes were not an option on the pump, so they were manually flushing both the G and J-tubes. If the tube became clogged there was a [MEDICATION NAME] order in place and should be attempted before sending the resident to the hospital. When the nurse used the [MEDICATION NAME] it would be documented in a progress note and signed in the MAR. If the MAR indicated [REDACTED]. If the resident needed to go have the tube changed, they would call the IR department. Sometimes it took a few days to get the resident in to IR. They would administer clysis when the tube was not able to be used. The tube feeding was supposed to be going through the J-tube. The RN reviewed the physician orders [REDACTED]. She stated the feeding could go into either tube. CNAs were not allowed to unhook the tube feeding or turn the pump on or off. If it was noticed that the tube feeding had been unhooked, she would expect the LPN to find out why. If the tube feeding needed to be held the supervisor would be notified and the physician on call would be contacted. She could not recall any discussion with the physician regarding the resident's tube being clogged or coming out. She was not aware of any time the resident had a crack in the tubing and tape was being applied to prevent leaking. If the tube was cracked the resident should have the tube changed. She reviewed the Nov. 2019 progress notes and stated the resident went out for the cracked tube and she had no knowledge of that. During an interview with the Registered Dietitian (RD) #27 on 2/27/2020 at 4:40 PM she stated the resident had been in and out of the hospital for respiratory issues and a clogged feeding tube. The resident's BMI (body mass index) and weight were low but stable on the current tube feeding regimen. She stated the medications were supposed to go through the [DEVICE] and the feeding through the J-tube but if the J-tube got clogged they would put the feeding through the [DEVICE] until it was changed. If a resident's tube was prone to clogging she would look at the type of formula. She had not made any changes to Resident #6's formula. The resident also frequently pulled out the G/J tube and would be sent to IR for replacement. She was aware the resident received clysis while waiting to go to IR for replacement. The resident would not be getting needed nutrients with just the clysis. The resident should not go more than 3 days on just the clysis as this could cause weight loss and skin breakdown. During an interview with RN #28 on 2/27/2020 at 5:10 PM she stated she remembered an issue with Resident #6 's G/J tube a few months ago. The LPN had called her into the room to report that the J-tube was leaking. There was a crack in the J-tube, and they were using the [DEVICE] to administer the tube feeding. The [DEVICE] was starting to get clogged so the nurse had tried to administer the tube feeding through the J-tube and it was leaking out of a the crack onto the resident's stomach and brief. The resident was so emaciated (abnormally thin) that she instructed the LPN to put a [MEDICATION NAME] over the crack because she did not want the resident to go without the feeding. She was called again to the resident's room around 2:30 AM and the tube had leaked stomach contents. She sent the resident to the hospital as the resident appeared malnourished and she was afraid the resident would quickly become dehydrated. During an interview with RN #29 on 2/28/2020 at 4:00 PM he stated he had worked as a nursing Supervisor. The resident did have a crack in the J-tube, it had been an ongoing problem and they had been putting tape on it and administering the feeding through the [DEVICE]. He instructed the nurse to put tape on the crack to prevent leaking. He said it had been an ongoing issue and he was sure the Unit Manager had been aware of it. During an interview with LPN #30 on 3/2/2020 at 3:30 PM she stated she would occasionally find the resident's tube feeding disconnected. The CNAs were not allowed to touch the tube or the feeding pump but would sometimes turn the pump off while they were providing care. She would tell them they could not do that. Resident #6 had just returned to the facility that week after having the tube changed due to clogging. The resident would receive medications through the [DEVICE] and the tube feeding through the J-tube. She stated one day the tube feeding would be going through the J-tube and the next day it would be going through the [DEVICE]. There was a time there was a crack in the J-tube and they used the [DEVICE] to prevent any leaking from the crack. The resident did have a history of pulling out the tube and she would make sure the resident's gown was pulled down and the resident's hands were outside of the covers. The resident did have an abdominal binder but does not always have it on. 10 NYCRR 415.12(g)(2)