STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455727	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK MANOR HEALTH CARE AND REHABILITATION	**207 E PARKERVILLE RD DESOTO, TX 75115**

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 0693 **Level of harm -** Immediate jeopardy **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 observation, interview and record review, the facility failed to ensure that a resident who was fed by enteral feeding received the appropriate treatment and services to prevent complications for one (Residents #1) of five residents reviewed for tube feedings. LVN A failed to correctly unclog Resident #1's [DEVICE] when it appeared clogged during a flush. LVN A used a declogger tool incorrectly on Resident #1's [DEVICE] that could have resulted in perforation of the [DEVICE] and/or intestinal wall. LVN A used the tool without training or a physician's order. Following the use of the tool, LVN A failed to complete an assessment on Resident #1 or notify the physician. An Immediate Jeopardy/Immediate Threat was identified on 08/03/20. While the Immediate Jeopardy was removed on 08/04/20, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm that is not Immediate Jeopardy, due to the facility's continuation of in-servicing and monitoring the plan of removal. The facility was provided the Immediate Jeopardy template on 08/03/20. These failures placed residents at risk for perforation of the [DEVICE] and/or intestinal wall, replacement of the [DEVICE], hospitalization , or even death. Findings included: Review of Resident #1's MDS assessment, dated 07/28/20, revealed the resident was an [AGE] year-old female admitted to the facility on [DATE] with a readmission on 07/21/20 from the hospital for [DEVICE] placement. The MDS assessment reflected Resident #1's cognition was severely impaired, and her [DIAGNOSES REDACTED]. The resident required the extensive assistance of two staff for activities of daily living and was totally dependent for eating ([DEVICE]). Review of Resident #1's comprehensive care plan, dated 07/21/20, revealed the resident had a goal for at risk of aspiration due to resident receiving nutrition by [DEVICE]. The care plan reflected no goals or approaches related to the use of a [DEVICE] declogger. Review of Resident #1's physician orders reflected: 07/21/20 100 ML of H20 (water) flushes every 4 hours via [DEVICE]. Further review reflected no physician's orders for use of a [DEVICE] declogger. Review of Resident #1's hospital transfer orders dated 07/21/20 reflected no order for the use of [REDACTED]. LVN A assessed for [DEVICE] placement and poured water into the 60 ML syringe. The water did not flow into the [DEVICE]. LVN A proceeded to massage the [DEVICE] and then wiggled the [DEVICE]. The water still did not flow into the [DEVICE]. LVN A obtained a declogger from the resident's beside table . LVN A that is then inserted a declogger, a flexible threaded device that is serrated approximately 2 inches at the end, into the [DEVICE] without measuring the length of the [DEVICE], verifying the correct size, and not turning the tool in a clockwise direction during insertion and counter clockwise during removal. Following the use of the tool, LVN A administered 100 ML of H20 without reassessing for placement of the tube. A review of the declogger packaging on 08/03/20 at 2:00 p.m. with the DON revealed the following instructions: (Brand Name) Declogger Rxd only Single use only 1. Determine the size of the gastric-tube 2. Select appropriate size declogger that corresponds to the size of the tube 3. Pause pump 4. Insert the declogger to the blockage and then slowly rotate two times in a clockwise direction and then reverse rotate 2 times in counter clockwise direction while removing it. Do not attempt to force the declogger through the entire blockage 5. Repeat X4 until the stop disk is reached without difficulty 6. Flush tube with 30-60cc of water 7. Once clear reconnect the delivery tube and restart the enteral feed Discard the declogger and document results. An interview with LVN A on 08/03/20 at 12:30 p.m. revealed she had not received any training for the use of a [DEVICE] declogger and this was the first time she had used one. Review of Resident #1's clinical nurses' notes reflected on 08/03/20 at 1:25 p.m. Resident #1's [DEVICE] was intact and patent feed with 100 cc H20 flush every 4 hours. There was no further documentation of an assessment, notification of physician of the use of the declogger, or follow-up of Resident #1's condition in the clinical record. An interview with LVN A on 08/03/20 at 2:20 p.m. revealed she was unaware of the different sizes of [DEVICE] decloggers and she did not know the size or length of Resident #1's [DEVICE]. LVN A stated she was unaware if Resident #1 had a physician's order to use the declogger. LVN A stated if a [DEVICE] was clogged normally she would use warm water, reposition the resident, assess and try again. She stated if that was not successful she would call the physician. LVN A was asked why she did not do that and LVN A said, I do not know. An interview with LVN A on 08/04/20 at 10:25 a.m. revealed she did not call the physician because the [DEVICE] flushed after she used the declogger and the resident did not exhibit any pain. When LVN A was ask why she did not document the use of the declogger, LVN A said, I do not know. When LVN A was ask if she was aware of the potential of the danger using the declogger without training and a physician's order, LVN A said, no. An interview with the DON on 08/03/20 at 1:52 p.m. revealed she did not know what a [DEVICE] declogger was and not seen one before. She stated she was unaware of LVN A using a [DEVICE] declogger on Resident #1. The DON stated she did not know that the declogger was in the building and being used. The DON stated to unclog a [DEVICE], staff should use warm water, massage the tube, and reposition the resident. She stated if the [DEVICE] was still clogged the physician must be notified. When the DON was asked about in-service training and policy and procedure related to the use of a [DEVICE] declogger, she stated there was none. An interview on 08/03/20 at 4:00 p.m. with the Medical Director revealed he was familiar with decloggers, but was not familiar with the specific brand used by LVN A. The Medical Director was informed about what had occurred with Resident #1. The Medical Director reviewed the specific declogger online and stated it was very dangerous to use the declogger and staff could perforate the [DEVICE] or the lining of the stomach. He stated if a [DEVICE] was clogged nursing staff should use warm water, massage the tube, reposition the resident and if that did not work they should notify him. The Medical Director stated he could not understand why a nurse would use the declogger without any training. The Medical Director stated he was not aware Resident #1's [DEVICE] was clogged and that a declogger had been used. He stated he should have been notified so he could make the decision about sending the resident to the hospital. An interview with LVN B on 08/03/20 at 12:55 p.m. revealed she knew what the [DEVICE] declogger was and had she had worked with [DEVICE] residents. LVN B said she had no training and she would not use the declogger even if she did. An interview with LVN C on 08/03/20 at 1:07 p.m. revealed he had worked with Resident #1, knew the declogger was in the facility, in each of the [DEVICE] feeders bedside table, on the medication carts, but had never used one and if you needed one you would ask the central supply staff to order you one if you could not find one. When LVN C was ask if he had received any training concerning the declogger, he asked, You have to have training to use one of those? LVN C stated he had no training to use a [DEVICE] declogger. An interview with LVN D on 08/03/20 at 1:10 p.m. revealed she was aware [DEVICE] decloggers were available but had never used one and had no training for the use of the declogger. An interview with LVN G on 08/03/20 at 3:45 p.m. revealed he was currently taking care of Resident #1. LVN G knew there were decloggers in the building, but he had not been trained on how to use one. LVN G stated that the decloggers were dangerous and he would never use one because how would you know how far to place the declogger in and you could perforate the tube. An interview with LVN E on 08/03/20 at 3:51 p.m. revealed she knew the decloggers were in the building but had not been trained on how to use one. An interview with LVN F on 08/03/20 at 3:53 PM revealed she had not been trained on using a

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 0693 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) [DEVICE] declogger and had not used one. An interview on 08/03/20 at 4:29 p.m. with LVN G revealed the nurses conducted Walking Rounds, at the change of shift, to discuss each resident. LVN G was asked if he was aware that the previous nurse had trouble with Resident #1's [DEVICE] flush and used a declogger, and he stated he had not been informed. LVN G stated he had assessed Resident #1 at 4:00 p.m. and administered the ordered flush with no problems. An observation on 08/03/20 at 2:30 p.m. revealed the DON removing a declogger from a bedside table of a resident's room on Hall 100. An interview with the DON on 08/03/20 at 2:32 p.m. revealed she was in-servicing the nursing staff on pulling the decloggers from the facility and they were not to be used. The facility did not have policy and procedure to use the declogger and the Medical Director said they were dangerous to use in this environment due to the potential of perforation. The DON stated she had done a full sweep of the building and removed all [DEVICE] decloggers from the treatment carts, medications carts, central supply, and residents' rooms. An interview with the DON on 08/03/20 at 3:22 p.m. revealed she had notified the Central Supply Staff, via sent text message, that she was not to order anymore [DEVICE] decloggers. Review of the article Best practices for unclogging feeding tubes in adults from the Nursing2018 journal, published June 2018, revealed: The American Society for [MEDICATION NAME] and Enteral Nutrition (ASPEN) recommends warm water as the best initial choice for trying to unclog a feeding tube. First, attach a 30- or 60-mL piston syringe to the feeding tube and pull back the plunger to help dislodge the clog. Next, fill the flush syringe with warm water, reattach it to the tube, and attempt a flush. If you continue to meet resistance, gently move the syringe plunger back and forth to help loosen the clog. You can then clamp the tube to allow the warm water to penetrate the clog for up to 20 minutes. Additional second-line interventions include using a commercially available enzyme declogging kit or mechanical declogging device. These also must be used in accordance with facility policy and procedure and only by experienced clinicians. If the tube can't be unclogged by these methods, ASPEN recommends replacing it. Access on 08/17/20 from https://www.nursingcenter.com/journalarticle?Article_ ID= 08&Journal_ID= &Issue_ID= 97 Review of the decloggers manufacture's recommendations on use of the Enteral Feeding Tube Decloggers revealed the following: Instructions on [MEDICATION NAME] Usage: PRECAUTIONS: Prior to any use of the product, the length of the feeding tube should be known. Use a declogger that is shorter than the feeding tube. Caution: Federal law restricts this device to sale by or on the order of a physician. DO NOT ATTEMPT TO FORCE THE DECLOGGER THROUGH THE ENTIRE BLOCKAGE. There are five different sizes and two lengths of the Declogger Proper Usage: You should understand what different occurrences cause clogs in enteral feeding tubes so you know why exactly you are unclogging a tube. Here are some examples: kinks in the lines of the tubes, not flushing after putting medication in, dense formulas, small-bore feeding tubes and slow flowing formula can sometimes cause residue that forms buildup. Gastric acids can mix with the formula when the gastric residuals are being checked. Review of the facility's current policy and procedure entitled Maintaining Patency of A Feeding Tube (Flushing) dated as revised October 2018 revealed the following in regard to clogged feeding tubes: Occlusion or clogged tube procedures 1. Check feeding tube for kinks. A kink is a twist or curl, as in a thread, rope, tube, wire, or hair, caused by its doubling or bending upon itself. 2. Attach sixty (60) cc syringe with plunger and gently pull back on the plunger to dislodge the clog. 3. If blockage remains, draw up 30 cc of warm water into the 60 cc syringe and gently instill water into the tube. Do not force fluid into tube. Gently pull back and forth on the plunger to dislodge the clog. 4. The feeding tube can be milked with fingers from the insertion site to assist in removing the clog. 5. If attempts are not successful, notify the physician. The facility's policy/procedure had no documentation in regard to using or not using a declogger. An Immediate Jeopardy/Immediate Threat was identified on 08/03/20. The Administrator and DON were notified of the Immediate Jeopardy on 08/03/20 at 5:02 p.m. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Facility's Plan of Removal for Immediate Jeopardy was accepted on 08/04/20 at 3:16 p.m. and reflected the following: 1. All nurses will be in-serviced by, Director of Nursing, for notification of decloggers and or any medical device used for those specific purposes will no longer be in facility and will not be allowed to be used in the facility Start Date 8/3/2020 -Completed 8/3/2020 a. Director of Nursing, Assistant Director of Nursing, and designated LVN H pulled all decloggers out of medication rooms, residents' rooms, and medication cart on 8/3/2020 2. All nurses will be in-serviced for [DEVICE] proficiency, care, and how to properly unclog g tubes for patency. If any resistance notify physician and obtain order to send resident out for [DEVICE] replacement. Inservice is being conducted by Director of Nursing, Assistant Director of Nursing, and designated LVN H. Start Date 8/3/2020 -Completed 8/4/2020 a. Room set up was established on 8/3/2020 for nurses to show return demonstration to Director of Nursing and Assistant Director of Nursing. Copy of proficiency check off is attached. 3. Nurses will be monitored of completion of [DEVICE] proficiency check off list Inservice by Director of Nursing, and Administrator. Start 8/3/2020-Completion Date 8/4/2020 a. Nursing staff will be required to attend, and complete proficiency check off on [DEVICE] b. Spreadsheet is being maintained by Administrator and Director of Nursing, will monitor to ensure staff completion of proficiency check off. 4. Central Supply will be in-serviced on not ordering Decloggers and notify (supplier) of blocking order for decloggers. Start Date 8/3/2020- Completed 8/3/2020 a. RN, VP of Clinical Services contacted Supply company and blocked the ordering of DeCloggers Completed 8/3/2020 b. Central Supply will bring nursing supply orders to Director of Nursing, and or designee for approval prior to ordering Completed 8/4/2020 5. Medical Director has scheduled inservice with nursing staff. Scheduled 8/4/2020 at 1:00pm a. Topics: Physician Notification, standing orders for [DEVICE], how to address [DEVICE] patency b. Staff not able to attend will be required to watch recording of Medical Director's training prior to next shift scheduled. Spreadsheet of completion is being maintained by Administrator and Director of Nursing. 6. Plan will be reviewed for the next 6 months during QAPI/QA Monitoring of the facility's Plan of Removal included the following: Interviews were conducted on 08/04/20 starting at 5:00 p.m. and continued through 08/05/20 at 4:50 p.m. with 18 staff members from various shifts regarding in-services which included [DEVICE] proficiency, assessment, care, physician notification, physician orders and how to properly unclog a [DEVICE]. The staff members were able to: Describe the correct process for assessing a [DEVICE]. Describe the process for care of a [DEVICE] Describe the process of how to properly unclog a [DEVICE]. Describe the process of when to call the physician. Describe the process of not treating a resident unless you have a physician order. Interviewed staff members and shifts were: LVN C- worked 6:00 a.m. to 2:00 p.m. and 2:00 p.m. to 10:00 p.m. LVN I- worked 2:00 p.m. to 10:00 p.m. (agency staff) LVN J- worked 10:00 p.m. to 6:00 a.m. LVN K- worked 10:00 p.m. to 6:00 a.m. LVN H- worked all shifts LVN L- worked 6:00 a.m. to 2:00 p.m. LVN M- worked 6:00 am to 2:00 p.m. (agency staff) LVN A - worked 6:00 a.m. to 2:00 p.m. LVN D - worked 6:00 a.m. to 2:00 p.m. LVN B - worked 6:00 a.m. to 2:00 p.m. LVN G - worked 2:00 p.m. to 10:00 p.m. LVN N - worked 2:00 p.m. to 10:00 p.m. RN O- weekend supervisor ADON- worked all shifts LVN Q- worked split shifts LVN R-worked 10:00 p.m. to 6:00 a.m. LVN E-worked 2:00 p.m. to 10:00 p.m. LVN F-worked 2:00 p.m. to 10:00 p.m. An interview with the DON on 08/05/20 at 2:00 p.m. revealed going forward the facility would be following the policy and best practice for assessment and care of residents with [DEVICE]s. She stated the nursing staff would be monitored for following physician orders with continued in-service and observation by the DON and ADON. An interview with the Administrator on 08/05/20 at 4:00 p.m. revealed going forward the facility would be following the policy for care and assessments of [DEVICE]s and the importance of physician orders. She stated she would ensure the facility completed and continued the proficiency training for [DEVICE]s. The Administrator was notified on 08/05/20 at 5:30 p.m., the Immediate Jeopardy was removed. While the immediacy was removed on 08/04/20, the facility remained out of compliance at a scope of pattern and a severity level of potential for more than minimal harm that is not Immediate Jeopardy, due to the facility continuing in-servicing and monitoring the plan of removal.