

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335225	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/25/2024
NAME OF PROVIDER OR SUPPLIER  Oak Hill Rehabilitation and Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  602 Hudson St Ithaca, NY 14850	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>37385</p> <p>Based on record review and interviews during the abbreviated survey (NY00356309), the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for 1 of 3 residents (Resident #1) reviewed. Specifically, Resident #1 received their nutritional needs through a tube feeding (delivery of nutrients through a feeding tube placed directly into the stomach). The feeding tube became dislodged, and the resident was not assessed timely by a qualified professional.</p> <p>Findings include:</p> <p>The facility policy, Gastrostomy Tube Feeding, effective 9/2024 documented:</p> <ul style="list-style-type: none"> <li>- when an intermittent feeding was completed, document the administration in the Medication Administration Order.</li> <li>- If at any time, the tube feeding or water flush was not administered per physician order, the physician must be notified for further instruction or orders.</li> </ul> <p>Resident #1 had diagnoses including unspecified protein calorie malnutrition, autistic disorder, and restlessness and agitation. The 9/12/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, was dependent for activities of daily living, had a feeding tube, and received 51% or more of their total calories through tube feeding.</p> <p>The 9/27/2024 physician order documented Osmolite 1.5 (liquid nutritional formula) at 80 milliliters per hour, continuous with 100 milliliters of water every 6 hours for 18 hours a day, first administration time 12:00 AM.</p> <p>The 9/30/2024 at 12:29 AM Licensed Practical Nurse #1 progress note documented at 11:50 AM (9/29/2024), they entered the resident's room to start a fresh container of feeding and new flush bag, the pump was already running. The feeding tube was out of place, beside the resident, with the balloon (anchors the tube in the stomach) inflated and the linens were saturated with feeding. The feeding was held, and the resident was placed on report to have the feeding tube replaced in the morning.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence the resident was assessed by a qualified professional or that a medical provider was notified following the dislodgement of the tube feeding.</p> <p>The 9/30/2024 at 9:04 AM Licensed Practical Nurse #2 progress note documented they called the hospital and left a message about having the feeding tube replaced.</p> <p>The 9/30/2024 at 9:05 AM Licensed Practical Nurse #2 progress note documented they notified the medical provider and the family the resident pulled out the feeding tube.</p> <p>The 10/1/2024 at 12:51 PM progress noted entered by the Director of Nursing (as a late entry) documented the resident was assessed following the feeding tube being pulled out. There were no signs or symptoms of discomfort, no sign of infection at the site. The hospital was called again for an appointment in radiology with no return call. Physician Assistant #14 was notified and ordered to send the resident to the emergency room for tube replacement.</p> <p>During an interview with Licensed Practical Nurse #2 on 10/9/2024 at 12:36 PM, they stated when they arrived on 9/30/2024 at 7:30 AM, Licensed Practical Nurse #1 informed them Resident #1 pulled out their feeding tube. When Licensed Practical Nurse #2 asked Licensed Practical Nurse #1 if they called anyone, Licensed Practical Nurse #1 stated they had not and they wrote a note. Licensed Practical Nurse #2 notified Physician Assistant #14 at 8:56 AM and received no new orders. Resident #1 received tube feedings over 18 hours and Licensed Practical Nurse #1 reported they found the feeding tube dislodged at approximately 11:30 PM on 9/29/2024. The resident had not received any medications, fluids, or nutrition following the removal of the feeding tube. A medical provider should have been notified due to the resident's feeding being and medications being held, as the nurse cannot make that decision without an order. The Director of Nursing should also have been notified in the absence of a registered nurse in the building, for guidance on assessment of the resident.</p> <p>During an interview with the Director of Nursing on 10/9/2024 at 4:00 PM and a follow-up telephone interview on 10/25/2024 at 1:09 PM, they stated they were first made aware of Resident #1's displaced feeding tube on 9/30/2024 by Licensed Practical Nurse #2. If there was no registered nurse in the building, staff were to call the Director of Nursing. They would provide guidance, could utilize video calls, gather information, and would advise if an assessment was required at that time. Registered Nurse Supervisor #3 lived very close to the facility and was always available to respond onsite for needed assessments if the Director of Nursing was not available. The medical provider needed to be notified anytime an order was held or not able to be completed, including tube feedings and medications. The medical provider should also have been notified due to the feeding tube dislodgment; in the event they wanted the resident sent to hospital. Licensed Practical Nurse #1 was to receive a formal discipline and education on this process; however, they had not responded to the Director of Nursing's calls and had since resigned from their position.</p> <p>10 NYCRR 415.12</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>37385</p> <p>Based on observation, record review, and interviews during the abbreviated survey (NY00356309) the facility did not ensure a resident who was fed by enteral means (delivery of nutrients through a feeding tube directly into the stomach) received the appropriate treatment and services to prevent complications for 3 of 3 residents (Residents #1, #2, and #3). Specifically, Residents #1, #2 and #3 received their nutritional needs through tube feedings and tube feeding documentation was unclear as to the duration and amount of feeding administered and received.</p> <p>Findings include:</p> <p>The facility policy, Gastrostomy Tube Feeding, effective 9/2024, documented:</p> <ul style="list-style-type: none"> <li>- when an intermittent feeding (tube feeding delivered through a feeding tube over short periods several times a day) was completed, document the administration in the Medication Administration Record.</li> <li>- If the tube feeding or water flush was not administered per physician order, the physician must be notified for further instruction or orders.</li> </ul> <p>1) Resident #1 had diagnoses including unspecified protein calorie malnutrition, autistic disorder, and restlessness and agitation. The 9/12/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, was dependent for activities of daily living, did not have a swallowing disorder, had a feeding tube, and received 51% or more of their total calories through a tube feeding.</p> <p>The 9/30/2024 at 12:29 AM Licensed Practical Nurse #1 progress note documented the resident pulled out their feeding tube.</p> <p>The 10/1/2024 at 11:43 PM Registered Dietitian #5 progress note documented the resident was sent to the hospital for feeding tube replacement and returned. The recommendation was to resume prior tube feeding regimen of cyclic (feeding by a pump in less than 24 hours in a day) feeds of Osmolite 1.5 (liquid nutritional formula that provides 1.5 calorie per milliliter) at 80 milliliters per hour over 18 hours.</p> <p>The 10/2/2024 physician order documented formula Jevity 1.5 (liquid nutritional formula with fiber that provides 1.5 calorie per milliliter), 80 milliliters per hour over 18 hours, start time 1:00 AM. The order was discontinued on 10/4/2024.</p> <p>There was no documented evidence of tube feeding administration from 10/2/2024 to 10/4/2024.</p> <p>The 10/4/2024 physician order documented Osmolite 1.5, 80 milliliters per hour over 18 hours, start time 1:00 AM. The order was discontinued on 10/9/2024.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 10/2024 Medication and Treatment Administration Records did not contain any documented evidence of the 10/2/2024-10/8/2024 tube feedings.</p> <p>The 10/9/2024 physician's orders documented:</p> <ul style="list-style-type: none"> <li>- Osmolite 1.5 at 80 milliliters per hour for 18 hours, intermittent, tube feed to be started at 8:00 PM</li> <li>- Osmolite 1.5 at 80 milliliters per hour for 18 hours, intermittent, tube feed to be disconnected at 2:00 PM</li> </ul> <p>During an observation on 10/9/2024 at 11:47 AM, Resident #1 had their tube feeding connected. A 33.8 fluid ounce (1,000 milliliters) bottle of Osmolite 1.5 was hung as well as a fluid bag on the pole. The Osmolite bottle was dated 10/9/2024 at 6:00 AM with Licensed Practical Nurse #6's initials. The tube feeding pump was set at 80 milliliters per hour, with 200 milliliter flush every 6 hours. The amount on the bottle was at the 750-milliliter line (250 milliliters infused, at 80 milliliters per hour is 3.125 hours).</p> <p>During an observation on 10/9/2024 at 1:15 PM, Resident #1 was in the doorway to their room in a geri-chair (a specialty reclining mobile chair) with the tube feeding disconnected. At 2:20 PM, Resident #1's feeding tube remained disconnected (they were reported to have been agitated). The Osmolite bottle was dated 10/9/2024 at 6:00 AM with Licensed Practical Nurse #6's initials. The amount on the bottle remained at the 750-milliliter line (250 milliliters infused, at 80 milliliters per hour is 3.125 hours). There were no markings on the bottle to show the time the bottle was disconnected.</p> <p>The 10/2024 Medication and Treatment Administration Records documented the tube feeding administration times:</p> <ul style="list-style-type: none"> <li>- on 10/8/2024, no tube feeding was noted;</li> <li>- on 10/9/224, stopped at 2:00 PM;</li> <li>- on 10/10/2024, started at 9:22 PM and stopped on 10/11/2024 at 2:00 PM (16 hours, 38 minutes);</li> <li>- on 10/11/2024, started at 10:30 PM, stopped on 10/12/2024 at 2:00 PM (15 hours, 30 minutes); and</li> <li>- on 10/14/2024, started at 1:04 AM, stopped on 10/15/2024 at 2:00 PM (12 hours, 56 minutes)</li> </ul> <p>There was no documentation related to the start and stop times of the tube feedings or notification of the medical provider or registered dietitian about the tube feedings.</p> <p>2) Resident #2 had diagnoses including cerebral infarction (stroke) and dysphagia (difficulty swallowing). The 8/13/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment, required maximum assistance for their activities of daily living, had a feeding tube, and received 51% or more of their total calories through tube feeding.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documented evidence in Resident #3's medical record the medical provider or Registered Dietitian was contacted related to a conflict in scheduled tube feeding times due to the unavailability of a feeding pump later identified during an interview with Licensed Practical Nurse #2. There was no documented evidence related to the late administration times.</p> <p>The 10/1/2024-10/8/2024 Medication and Treatment Administration Records for Residents #2 and #3 documented tube feeding administration times were completed on time for 17 administrations, scheduled at the same time.</p> <p>During an interview on 10/9/2024 at 12:36 PM Licensed Practical Nurse #2 stated Resident #1's tube feeding was intermittent meaning they stopped and started the tube feeding. Resident #2's feedings were bolus every 6 hours. The licensed practical nurse clarified Resident #1's order today with the Director of Nursing, to reflect a start and stop time for an 18-hour schedule. If the resident became agitated, they may pull at the feeding tube, so the tube feeding would be paused until the resident was calm again. The feeding could go over 18 hours if they had to pause the feeding. Licensed Practical Nurse #2 stated when they arrived this morning, Resident #1's tube feeding was not connected. They located the bottle on the counter by the sink in the resident's room, with the bottle open and the tube connected with formula in the tube, indicating it had been running. The licensed practical nurse stated the nurse from the prior shift, Licensed Practical Nurse #6, did not verbally report the time the tube feeding was started or stopped, and they could not locate any documentation in the resident's record. Licensed Practical Nurse #6 reported to them that Resident #2's 6:00 AM tube feeding was done. Their next scheduled administration time was 12:00 PM, which a was late at this time due to Resident #1 still using the pump. There was another tube feeding pump being used by Resident #3, and there were no other feeding pumps in the building to use. Licensed Practical Nurse #2 stated they had been sharing 2 feeding pumps among 3 residents for approximately 1 1/2 weeks. Licensed Practical Nurse #2 was unaware of how long the tube feeding for Resident #1 had been paused or when it was started prior to their arrival on this day. They stated Licensed Practical Nurse #6 may have started Resident #1s feeding and stopped it to do Resident #2's 6:00 AM feeding. Licensed Practical Nurse #2 had to reset the pump for Resident #1's feeding rate at 7:30 AM, when they restarted the feeding. They stated they were unaware of the reason Licensed Practical Nurse #6 pierced the formula bottle for Resident #2 if they already completed their 6:00 AM feeding. Licensed Practical Nurse #2 stopped the feeding this afternoon due to the resident's agitation. They stated they looked at the bottle to see how much formula was gone, but it was hard to tell how much or how long the feeding had been running for the total 18-hour feeding. They did not document the start and stop times of the feedings and that was one reason they clarified the order today, to reflect the times. If they stopped the feeding for Resident #1 during the 18-hour cycle, they looked at the bottle to see how much was gone. At the time of the interview (2:15 PM), Licensed Practical Nurse #2 had not completed Resident #2's 12:00 PM scheduled feeding.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/16/2024 at 12:07 PM Registered Dietitian #5 stated they used the term cyclic feeding, meaning a tube feeding was administered over a designated time frame within a 24-hour period. The facility used the term intermittent, which the dietitian would consider the same as cyclic. Resident #1 should receive tube feedings of Osmolite 1.5 at 80 milliliters per hour over 18 hours. Registered Dietitian #5 stated if the resident's 18-hour feeding was interrupted due to care or behaviors, it would be up to nursing staff to determine how they were tracking the time of the interruptions and when the feeding was resumed. The expectation would be to extend the feeding beyond the 18-hour period if there was an interruption to ensure a full cycle was completed. The dietitian was not made aware that the facility was sharing 2 feeding pumps among 3 residents. They should have been notified to assist in obtaining another pump. The risk of sharing pumps was interrupted feeding schedules or late administration. If the dietitian was made aware, they could have recommended an alternate feeding schedule for the residents on bolus feedings, as it would not be appropriate to interrupt Resident #1's 18-hour cycle.</p> <p>During a telephone interview on 10/18/2024 at 2:14 PM Licensed Practical Nurse #6 stated continuous tube feeding meant the tube feeding ran constantly over a 24-hour period. Intermittent tube feeding meant the tube feeding was stopped for a couple of hours and then resumed. The nurse was not familiar with the facility using the term cyclic in terms of tube feeding schedules. Resident #1's tube feeding ran for 18 hours, and they thought they could stop it for 2 or 3 hours. They kept track of when the tube feeding was on and off by verbal nurse to nurse report. They had 24-hour reports and may also write down their own notes, but for Resident #1, all the nurses knew the schedule and did not write about Resident #1's feeding schedule on the 24-hour report or their own notes. They were not aware there was no sign off in the Medication or Treatment Administration Record for Resident #1's tube feedings from 10/2/2024 to 10/9/2024. When they started a new bottle or tube feeding, they wrote their initials, time, and date on the bottle. On 10/9/2024, they stated they hung Resident #1's tube feeding at 6:00 AM. They were unaware of the reason Licensed Practical Nurse #2 stated they found the bottle disconnected in the morning. They could not recall having to stop Resident #1's feeding to complete Resident #2's feeding. The nurse stated they pierced the tube feeding bottle, connected the tubing, initialed, dated, and timed the bottles at the time of administration. They would not puncture a bottle and prepare it for the next shift, as they were not responsible for that shift, and the bottle was only good for 24 hours after opening. They thought they may have prepared Resident #2's bottle for the 6:00 AM feeding and the other pump was not available, so they left it for the next shift to do. They did not use Resident #1's pump for feeding Resident #2. They alternated the other pump between Residents #2 and #3.</p> <p>(continued on next page)</p>		

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