STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675779	A. Building B. Wing	06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marine Creek Nursing and Rehabilitation	3600 Angle Ave Fort Worth, TX 76106

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview and record review, the facility failed to ensure residents who needed respiratory care, including tracheostomy care was provided such care, consistent with professional standards of practice for one (Resident #1) of eight residents reviewed for tracheostomy care. The facility failed to use the recommended amount of pressure (maximum of 25 cmH2O) per manufacturer to inflate Resident #1's tracheostomy tube cuff, which led to chronic over inflation and caused remodeling of the residents T1 and T2 vertebra and swallowing difficulty that likely caused starvation ketoacidosis (metabolic state after prolonged deprivation of glucose as primary source of energy). An Immediate Jeopardy (IJ) was identified on [DATE]. An IJ Template was provided to the facility on [DATE] at 3:30 PM. While the Immediate Jeopardy was removed on [DATE] at 3:23 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could affect residents with tracheostomies by placing them at risk for the development of infections and tracheal issues, and result in serious harm or death. Findings Included: Record review of Resident #1's face sheet, dated [DATE], revealed the resident was a [AGE] year old male who initially admitted to the facility on [DATE] and readmitted on [DATE] the following diagnoses: acute respiratory failure with hypercapnia (respiratory failure due to too much carbon dioxide in blood), tracheostomy status, mild protein0calorie malnutrition, major depressive disorder (mood disorder), Amyotrophic Lateral Sclerosis (nervous system disorder), dysphasia (difficulty swallowing), and aphonia (inability to produce voiced sound). Record review of Resident #1's annual MDS Assessment, dated [DATE], revealed the resident's BIMS score was 0, indicating it was unable to be assessed. The MDS Assessment reflected Resident #1 was usually able to make self understood and understood others. Further review revealed Resident #1 was dependent on staff for all ADLs and required respiratory treatments (oxygen therapy, suctioning, invasive mechanical ventilator, and tracheostomy care). (continued on next page)

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

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan, dated [DATE], reflected the resident had a tracheostomy with interventions to ensure tracheostomy ties were secured, humified oxygen was provided as prescribed, respiratory rate, depth and quality was monitored, and to monitor/document any restlessness, agitation, confusion, or increased heart rate .Further review reflected Resident #1 was resistive to care that included medications, meals, treatments, weights, showers and repositioning with interventions in place to allow the resident to male decisions about treatment regime and educate resident/family on possible outcomes. Record review of Resident #1's physician orders, dated [DATE], reflected the following: -Fortified/enhanced diet-regular texture, regular consistency-start date of [DATE], end date of [DATE]. -Remove G-tube per resident's request-start date [DATE], end date indefinite. -Tracheostomy Care, start date of [DATE], end date indefinite. No specific orders for amount of pressure in tracheostomy tube cuff. Record review of Resident #1's nursing notes, dated [DATE] at 10:33 AM, by LVN B revealed in part: .Resident #1 was found unresponsive by staff when entered room to feed for breakfast. [Resident #1] did not respond to touch or voice stimuli. V/S obtained BP ,d+[DATE], RR 16, HR 150, O2 98 on vent. [Resident #1] had change in condition. 0730 [sic] Phoned emergency services to have [Resident #1] transported for eval. [EMS] arrived. Phoned [MD] and made aware. Phone [RP], no answer . Record review of Resident #1's consolidated physician orders, dated [DATE], reflected the resident had an active order for a fortified/enhanced diet with NRA in place to have a regular diet. Further review reflected there was not an active order for pressure to be used in the resident's tracheostomy tube cuff. Record Review of Resident #1's documented weights at facility reflected the following: [DATE]-98.6 lbs. [DATE]-103.0 lbs. [DATE]-103.8 lbs. [DATE]-103.0 lbs. [DATE]-103.4 lbs. [DATE]-111.0 lbs. [DATE]-106.4 lbs. [DATE]-107.4 lbs. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]-107.4 lbs. [DATE]-107.0 lbs. [DATE]-106.6 lbs. [DATE]-103.2 lbs. [DATE]-110.8 lbs. [DATE]-110.8 lbs. Record review of Resident #1's speech-language pathologist evaluation, dated [DATE], reflected in part the following: Reason for referral/Current illness: Patient was referred to ST services following nursing staff reports of communication breakdown and need for updated NRA following transfer from sister facility. Patient refuses any assessment; however, makes ill face including rolling eyes when ST discussed modified diet options and MBSS. Patient challenged to make eye contact with ST if desires to continue previous NRA from sister facility including consumption of regular texture and thin liquids which was completed. Record review of Resident #1's hospital records, dated [DATE], reflected in part the following: [Resident #1] presented to the ED (on [DATE]) via EMS after being found unresponsive and hypotensive. [Resident #1's] diagnoses included hypotension (low blood pressure), septic shock, leukocytosis (high white blood cell count), acute metabolic acidosis (too much acid in body), severely overinflated tracheostomy cuff, and refeeding syndrome (reinstitution of nutrition from being starved/severely malnourished). Per chart review, [Resident #1's] PEG tube was removed ,d+[DATE] as [Resident #1] was tolerating PO intake, however unknown if [Resident #1] had been eating since due to overinflated tracheostomy cuff. [Resident # 1's] diagnosis of starvation ketoacidosis (metabolic state after prolonged deprivation of glucose as primary source of energy) is likely due to overinflated tracheostomy cuff. [Resident #1's] weight was as 112 lbs. [Resident #1] had remodeling of T1 and T2 vertebra due to chronic overinflation of tracheostomy cuff. In an interview on [DATE] at 8:45 AM, RN A at local hospital stated Resident #1 had severe protein-energy malnutrition. RN A stated Resident #1 previously had PEG tube, but it was removed by the nursing facility for unknown reason; however, the plan was to have it replaced during stay hospital. RN A stated Resident #1 was eating PO at the hospital with extensive assistance from staff. RN A stated she could not provide further information as she was new to the resident's case. In an observation and interview on [DATE] at 9:00 AM, Resident #1 was observed at the local hospital with ventilator and tracheostomy in place. Resident #1 was unable to communicate verbally; however, he blinked once to indicate Yes and blinked twice to indicate No. When asked if he was being fed PO by staff at the nursing facility, Resident #1 blinked twice to indicate No. Resident #1 attempted to verbalize something but was unable to be understood. Resident #1 was unable to write responses due to paralysis caused by Amyotrophic Lateral Sclerosis (nervous system disease). Resident #1 became agitated with inability to effectively communicate and did not complete a full interview. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 1:47 PM, the DON stated Resident #1 was admitted to the facility from a different nursing facility and admitted with weighing approximately 112 lbs. with malnutrition from refusal to take nutrition by PEG tube as well as PO. The DON stated Resident #1 signed a NRA to eat PO at previous facility that was still currently valid. The DON stated Resident #1 was educated on the risks of removing his PEG tube and eating PO . The DON stated Resident #1 made the decision to have his PEG tube removed in ,d+[DATE] because he only wanted to eat PO; however, the resident still often refused to eat PO. The DON stated Resident #1 was also resistive to other care including medications. The DON stated Resident #1's right to refuse could not be violated, so they just documented all refusals. The DON stated she was unaware that Resident #1's tracheostomy cuff was overinflated. She stated although she was over clinicals, the facility had a respiratory team with a lead who oversaw respiratory/tracheostomy care. In an interview on [DATE] at 2:15 PM, LVN B stated she worked at the facility for about 2 weeks, 6a-6p. She stated she worked with Resident #1 on [DATE] when he was found unresponsive in his room. She stated the resident appeared to be fine when she first arrived on shift and did rounds. LVN B stated an aide attempted to wake Resident #1for breakfast and he would not respond so the aide alerted her. LVN B stated she immediately went in to assess Resident #1. She stated she checked his vitals, and they were abnormal, and the resident was unresponsive so she called emergency services and notified the MD. LVN B stated Resident #1 was usually compliant with care during her shift, but it was reported that he could sometimes be non-compliant. In an interview on [DATE] at 2:22 PM, the MD stated the facility had been trying to convince Resident #1 to go on palliative/hospice care due to continuous refusal of care including meals and medications. The MD stated placing Resident #1 on palliative/hospice care would have protected the facility and providers while they honored Resident #1's right to refuse care; however, they could not get the resident to agree, and it was difficult to contact the resident's RP to help make decisions. The MD stated the facility was afraid that something would happen to Resident #1 before they could put a plan in place. The MD stated he could not provide information on tracheostomy care/cuff inflation as it was not his specialty. In an interview on [DATE] at 2:37 PM, the Lead RT stated she worked at the facility for 2 years. She stated Resident #1 was adamant about staff adding more air to his tracheostomy tube cuff even after he reached his volume. The Lead RT stated Resident #1 would become angry if staff did not add more air when he asked for it. The Lead RT stated she would never add more air but would sometimes pretend to keep Resident #1 calm. She stated other RTs were probably adding more air to prevent Resident #1 from being upset but she would tell them not to do so. The Lead RT stated the risk of overinflating a tracheostomy tube cuff could be breakdown of the throat and increased swallowing issues. In an interview on [DATE] at 2:58 PM, the Pulmonary NP stated it had not been reported to him by the RTs that Resident #1's tracheostomy tube was being overinflated or that there were any issues with it. Pulmonary NP stated it was not standard practice to more than the recommended amount or pressure to a tracheostomy tube cuff just because a resident requested it. He stated the risk of overinflating a tracheostomy tube cuff could be damage to tracheal wall, weakened tracheostomy balloon and possible swallowing issues depending how overinflated the cuff was. Pulmonary NP stated the RTs provided the care and he only came once a week to see the residents, so he did not want to be on record proving misinformation and did not continue interview. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 9:00 AM, RT C stated she worked at the facility for a little over a year. She stated tracheostomy care consisted of cleaning around the stoma, replacing the inner cannula, replacing the gauze. She stated tracheostomies were changed out per order and as needed. RT C stated the tracheostomy tube cuff was inflated according to recommended amount of pressure which differed depending on type of tracheostomy tube, then inflated as needed. She stated Resident #1 would sometimes ask for more air in his tracheostomy tube cuff, but she would not do it. RT C denied observing or hearing about other RTs overinflating Resident #1's tracheostomy tube cuff. RT C stated all RTs were trained a few times throughout the year on tracheotomy care and in-serviced as needed. In an interview on [DATE] at 11:09 AM, the RD stated she had been contracted with the facility for over 6 years. She stated she worked with Resident #1 at current nursing facility as well as at the previous facility. The RD stated Resident #1 was always picky about what he ate and would often refuse meals. She stated staff would sometimes buy food from outside so he would eat. The RD stated even at the previous facility Resident #1 would trigger for weight loss because he was refusing to eat. She stated she tried to talk to Resident #1 about trying supplements to increase nutrition and he refused. She stated she was not aware of any issues with Resident #1's tracheostomy tube cuff that could have been associated with his refusal to eat, so she attributed his weight loss/malnutrition to his refusal to eat. Further interview on [DATE] at 2:00 PM, The Lead RT stated Resident #1's neck was already broken down and distended which is likely why he felt the need for more air to feel comfortable. The Lead RT stated Resident #1 admitted to the facility with those issues and his tracheostomy cuff was probably overinflated in the past, and once the damage was done it had to be continued to hold the resident's volume. The Lead RT stated the pulmonologist (NP) was not notified about Resident #1's tracheostomy cuff being overinflated because it was a normal thing for him. She stated it was not really considered an overinflation because Resident #1 just needed more pressure than normal due to the anatomy of neck with it being so distended. The Lead RT stated the amount of pressure that wet into the tracheostomy tube cuff was different for each resident; however, the standard was normally ,d+[DATE] cm of H2O and the manufacturer's recommendation was always written on the packaging of the tracheostomy tube. In an interview on [DATE] at 12:30 PM, The Administrator stated the medical director and Lead RT were ultimately responsible for overseeing the care provided to residents receiving respiratory/tracheostomy services; however, communication was kept with the DON. The Administrator stated the Lead RT was very knowledgeable of respiratory/tracheostomy care and aware of residents' needs. In an interview on [DATE] at 2:59 PM, Resident #1's RP/family stated he had concerns that he had not been informed by the facility about the change in the resident's condition over time. He stated the facility would only notify him once Resident #1 was ill enough to be sent out to the hospital. The RP stated he was shocked to find out from the local hospital how malnourished Resident #1 was when he arrived and that it was due to his tracheostomy tube cuff being severely overinflated for a long period of time, preventing the resident from eating properly. He stated he was aware that Resident #1 opted to have his PEG tube removed last year because he could tolerate solid food and the facility had not informed him of any changes. The RP stated he was under the impression that Resident #1 was still eating solid foods well. He stated his schedule prevented him from always being available right away, but he would always return calls from anytime the facility tried to reach him. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review on [DATE] at 3:45 PM of National Library of Medicine, dated [DATE], revealed in part the following: Starvation ketoacidosis Clinically relevant forms of ketoacidosis include diabetic ketoacidosis, alcoholic ketoacidosis, and starvation ketoacidosis. Starvation ketoacidosis occurs after the body is deprived of glucose as its primary source of energy for a prolonged time, causing fatty acids to replace glucose as the major metabolic fuel. Record review of the facility's policy titled Tracheostomy Care Procedure, revised [DATE], reflected it did not address inflation of the tracheostomy cuff. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 03:07 PM. On [DATE] at 3:31 PM the DON was notified of the IJ situation . The IJ template was provided to the DON, and a plan of removal (POR) was requested at that time. The POR was accepted on [DATE] at 11:25 AM. The POR reflected the following: [facility] Date: [DATE] Plan of Removal Problem: F695 The facility failed to ensure that a resident who needed tracheostomy care, was provided such care consistent with professional standards of practice by over-inflating Resident #1's tracheostomy tube cuff, causing changes to the resident's T1 and T2 vertebrae, and placing him at risk of malnutrition, aspiration/pneumonia, and infection. Interventions: As of [DATE], resident #1 remains admitted to the hospital. On [DATE] twenty-four tracheostomies were checked by the DON, Regional Compliance Nurse, and Lead RT for proper inflation not to exceed 25 cm H2O per manufacture recommendation. There were twenty-two with inflatable cuffs and they were all within the guidelines. The medical director was notified of the immediate jeopardy by the administrator on [DATE]. AD HOC QAPI was held with the Medical Director and facility interdisciplinary team on [DATE] to discuss the immediate jeopardy and subsequent plan of removal. In-services As of [DATE], all Respiratory Therapists will be in-serviced 1:1 by the Lead Respiratory Therapist on the following: All staff not present will not be allowed to work their next shift until they are in-serviced. All PRN and agency staff will be in-serviced prior to the start of their next scheduled shift. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Abuse and Neglect- Over inflating a cuffed tracheostomy could cause a change in condition which include injury, unresponsiveness, difficulty swallowing, swelling, neck distention, and deceased appetite. o Trach cuffs will only be filled to manufacture recommendations. Respiratory therapist to notify physician immediately if more than 25 cm H2O is required in trach cuff. No exceptions unless documented by the Pulmonologist. o If the manufacture recommendation is not sufficient for an individual's tracheostomy the Pulmonologist will be contacted for oversight and direction. If the Pulmonologist cannot be reached the resident will be sent out 911. Monitoring: The Lead Respiratory Therapist will observe 5 trach cuff inflations per week to ensure correct pressure has been applied according to manufacture or pulmonologist recommendations. This monitoring will continue weekly for 6 weeks. The DON will ask 3 Respiratory Therapists per week, what would you do if a trach cuff needed more than 25 cm H2O? Did respiratory therapist respond appropriately? This monitoring will continue weekly for 6 weeks. Monitoring of POR on [DATE] included the following: Record review of Residents #1, #2, #3, #4, #5, #6, #7, and #9's, who all had tracheostomies were care planned and receiving appropriate tracheostomy care per physician orders and/ or recommended standards. Record review of 1:1 in-service on abuse/neglect, proper inflation of tracheostomy cuffs, and notifying the physician, dated [DATE], reflected RTs were in-serviced by the Regional Compliance Nurse. Review of document provided by the Administrator, dated, [DATE], reflected tracheotomy audits had completed on residents with tracheostomies by the Regional Compliance Nurse, DON, and Lead RT. Record review of QAPI sign-in sheet, dated [DATE], revealed a meeting was held to review the company's tracheostomy cuff inflation policy and need for an immediate change process. Interviews on [DATE] from 11:30 AM to 3:30 PM were conducted with Lead RT, RT C (6a-6p shift), RT D (6a-6p shift), RT E (6p-6a shift), RT F (6A-6P shift), and RT G (6p-6a shift). All interviewed staff were able to provide competency regarding in-services over abuse/neglect, following manufacturer's recommendations for inflation of tracheostomy cuffs, and notifying the physician if a resident requires more than the recommended amount of pressure for inflation and any other concerns. The Lead RT stated it was her responsibility to oversee the care being provided by the RTs and to monitor tracheostomies daily. Observation on [DATE] at 1:15 PM-1:25 PM of Residents #5, #7, and #8 tracheostomy care revealed the cuffs had the recommended amount of pressure and no concerns with care provided. (continued on next page)

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