STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676081	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East View Healthcare	15880 Wallisville Road Houston, TX 77049

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 - 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** 41469 Based on observation, interview, and record review, the facility failed to prevent complications of enteral feeding including but not limited to dehydration in one of two residents (Resident #52), in that: - Resident #52's pump history reflected the resident only received 37.5% of his enteral order in the past 24 hours. - Resident #52's pump history reflected the resident's tube feeding was stalled for 3 hours. - LVN B and ADON B were unaware of the resident's inadequate intake. The failures placed all resident on tube feedings at risk of malnutrition and dehydration. Findings included: Record review of Resident #52's face sheet revealed [AGE] year-old male who was admitted into the facility on [DATE] and was diagnosed with dysphagia (difficulty swallowing) following cerebral infarction (heart attack), hemiplegia (paralysis of one side of the body) and hemiparesis (inability to move one side of the body). Record review of Resident #52's MDS, dated [DATE], revealed the resident had a BIMS score of 3, indicating severed cognitive impairment, and the resident had a feeding tube. Record review of Resident #52's care plan, dated 03/01/2023, reflected the resident required tube feeding related to dysphagia, weight loss and malnutrition and the goal was to maintain adequate nutritional and hydration status as evidenced by table weight and no signs of malnutrition or dehydration through review target date of 12/07/2024. Record review of Resident #52's orders revealed, starting on 09/09/2024, the resident was on Isosource HN at 65ml/hr for 22 hours and a 200ml water flush every 6 hours (totaling 1430ml of enteral feed or 1716 kcals and 800ml of free water every 24 hours and). The order also specified that the pump may be off for ADL care. Other general tube enteral feed orders such as checking G-tube placement and water flushes between medication administration were in place since 03/26/2023 reflecting Resident #52's long term use of the G-tube. (continued on next page)

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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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #52's weight log revealed the resident had a stable weight ranging from 109.3 - 112.6 lbs in the past 3 months (06/10/2024 - 09/09/2024). Record review of Resident #52's nutrition assessments dated 08/28/2024 revealed the RDN wrote: .TF provides: 1716 kcals, 77 g protein, 1155 mL of H2O, flush provides an additional 800 ml of fluid . Resident at increased risk for dehydration and/or weight fluctuations d/t EN and PMH. Staff provides flushes and EN remains appropriate at this time. Anthro: Ht: 71 Wt 111.2# DBW 172+-10% BMI 15.5, underweight . Est needs based on IBW: 78.2 kg (25-30) ~ 1563-1954 kcal . Recommendations: No new nutrition intervention needed at this time, continue current plan. RD will continue to monitor wt status and EN tolerance . Observations on 09/17/2024 at 10:34AM, revealed Resident #52 was lying in bed asleep. His tube feeding pump was on and documented to be hung up by 6:30AM. Out of the 1000ml bag of enteral feed, approximately 850 ml remained. The pump's screen was seen to have an error message and the feed was on hold. Observations on 09/17/2024 at 11:40AM, revealed Resident #52 was still lying in bed asleep with his tube feeding pump screen still showing an error message while the enteral feed was on hold. Out of the 1000ml bag of enteral feed, approximately 850 ml remained. Observations on 09/17/2024 at 12:10PM, revealed the error on Resident #52's pump was resolved and the feeding was flowing at the ordered rate of 65ml/hr. In an interview with Resident #52 on 09/17/2024 at 2:35PM, when asked if he felt hungrier than usual, he stated Yes. Interview with ADON B and observations of Resident #52's pump on 09/17/2024 at 2:37PM revealed the ADON checked the pump history and stated something was off about it and that she would have to investigate to find what the issue was. She stated Resident #52's pump was ran continuously but was turned off for ADL care. The pump history revealed that the enteral feed was stalled for at least 3 hours during the shift after 130ml was already administered, in the past 24 hours, the resident was only administered 537ml of enteral (equating to only 643kcals) and in the past 48 hours, the resident was only fed 1326ml (equating to only 1591kcals) of enteral feed and 1400ml of free water. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with LVN B on 09/17/2024 at 3:14PM, she stated she was the charge nurse over Resident #52 and worked 6AM to 6PM. She said she did not know about the error message on Resident #52's pump. She stated she normally checked on her residents at 8am towards the beginning of her shift and again around 11AM or 12PM when she was done passing her medications. She stated she was not the one who checked on Resident #52 and fixed his pump but if the pump was noticed to have an error, it should have been brought to her attention so she could resolve it. She stated Resident #52 had been using the same pump and he had not left the facility recently for any reason. She stated nurses use to document the amount of enteral feed administered each shift and clear the history before shift change so they could better keep track of the amount that was administered to the patient, but they no longer did that. She stated that nurses just checked to ensure the flow rate matched the order. When reviewing Resident #52's pump history, she acknowledged that the feed had stalled for three hours and the total amount of 537ml fed in the past 24 hours was too low to meet his needs. She said the only reasons the enteral feed should be paused was when ADL care was being provided. She stated there could be a delay in the aides reporting to nurses when care ADL care was completed, thus causing a delay when resuming the enteral feed. She stated the risk of a resident not getting enough enteral nutrition could include malnutrition and possible weight loss. In an interview with ADON B on 09/18/2024 at 02:27 PM, she stated since the observation of Resident #52's pump, she reported the issue to the RDN and asked her to review the pumps and provide an in-service on how to review administration history on the pumps. She said it seemed like there could have been an issue with the pump but she could not speculate why it was low. She stated she knew that the resident was at risk for dehydration, skin breakdown and malnutrition, especially being on hospice. In an interview with the DON on 09/19/2024 at 9:19AM, she stated a previous dietitian they had as part of staff recommended documenting a resident's enteral feed administered at the end of every shift, but since switching dietitians, they stopped doing so. She stated there could have been a complication with the pump that caused the resident to only get 0% of his needs. She stated she had never audited pumps to ensure they worked properly. She stated the risks of a resident not receiving enough enteral nutrition included skin break down, dehydration and a caloric deficit. In a phone interview with the RDN on 09/19/2024 at 01:09PM, the RDN stated Resident #52 had a continuous enteral feed order to be administered for approximately 22 hours leaving about 2 hours for ADL care throughout the day. She stated she calculated his enteral feed order based on his ideal body weight of 172lbs since he was already underweight. She stated if the resident was only fed 537ml or 644 kcals in the past 24 hours, and 1326ml or 1591 kcals over the past 48 hours, that was too low to meet the resident's nutritional needs. She stated it placed the resident at risk for malnutrition, dehydration, weight loss and instability. She stated she had never noticed any issues with the pumps before and had never had to do an in-service with the nursing staff on how to check pump history. Record review of the facility's policy on enteral nutrition, not dated, reflected, . Intake and output will be recorded every shift on enteral residents .