STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676300	A. Building B. Wing	07/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canton Oaks	1901 S Trade Days Blvd Canton, TX 75103

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 to resident health or safety 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** 41093 Based on interview, and record review, the facility failed to ensure that residents receiving enteral feeding received appropriate care and services to prevent complication of enteral feeding for 1 of 1 resident (Resident #1) reviewed for enteral feeding. The facility failed to ensure Resident #1's tube feeding was stopped at 7:00 a.m. as ordered. Resident #1 received the tube feeding and water flushes via the pump for approximately an additional 6 and 1/2 hours resulting in an excess volume delivery of 1072mls Resident #1 began vomiting, was found cyanotic (when the skin, lips or nails turn a bluish color) and had an Sp02 (oxygen saturation level -normal rage is 95-100%) of 52% and was transferred to the hospital where he was diagnosed with aspiration pneumonia (when food or liquid is breathed into the airways or lungs) ,acute respiratory failure (a sudden life threatening condition where there's not enough oxygen or too much carbon dioxide in the body, which can be caused by aspiration) and required intubation in the intensive care unit. An Immediate Jeopardy (IJ) was identified on 7/22/24 at 4:26 p.m. While the IJ was removed on 7/23/24, 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 that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could affect residents receiving tube feedings by placing them at an increased risk of aspiration, fluid overload and death. Findings included: Record review of the face sheet for Resident #1 indicated he was [AGE] years old, readmitted to the facility on [DATE] with diagnoses including HIV disease (human immunodeficiency virus) gastrostomy malfunction (malfunction of opening into the stomach from the abdominal wall, made surgically for the introduction of food) , dysphagia (difficulty or discomfort in swallowing) quadriplegia (paralysis of all four limbs) and unspecified protein-calorie malnutrition. (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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(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 to resident health or safety Residents Affected - Few	Record review of the MDS dated [DATE] indicated Resident #1 sometimes understood others and sometimes made himself understood. The MDS indicated Resident #1 was cognitively intact (BIMS of 15). The MDS indicated Resident #1 was dependent on staff for eating, toileting, showering, dressing the upper and lower body, putting on and taking off of footwear, and personal hygiene. The MDS indicated Resident #1 had an active diagnosis of quadriplegia. The MDS indicated Resident #1 had a feeding tube and a mechanically altered diet during the 7 days look back period. The MDS indicated Resident #1 had received 51% or more of his total calories through tube feeding and 501 cc/day or more of his fluid intake by tube feeding daily during the seven days look back period . Record review of the care plan, revised on 6/4/24, indicated Resident #1 received tube feedings related to dysphagia. The care plan interventions included, elevate the head of bed 30-45 degrees during feeding and one hour after; check residual if residual 150 ml or less reinsert volume into stomach and continue feeding-If greater than 150 ml hold feeding and notify physician; and monitor for signs/symptoms of tube feeding intolerance. Record review of the active physician order dated 2/21/24 revealed Resident #1 was to be administered enteral feeding (Enteral nutrition refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver nutrition and calories) with Jevity 1.5 at 90 cc/hr from 5:00 p.m. to 7:00 a.m. via pump per G-tube with a 75 cc water flush via the G-tube per hour. Record review of the active physician order dated 4/2/24 indicated Resident #1 was to be administered a mechanically altered diet with nectar thick liquids and chopped meats. Record review of the nursing progress note dated 7/18/24 at 2:30 p.m., for Resident #1 stated At 1356 (1:56 p.m.) this nurse was called into the resident's room by the charge nurse. Charge nurse reported that res. (Resident) had vomited and nurse realized she had not turned tube feed off at 7:00 a.m. When this nurse entered the room the resident appeared cyanotic and abd (abdomen) distended. This nurse immediately began suctioning and turned resident to the side when vomiting applied nonrebreather r/t (related to) Sp02 at 52 %. Residents 02 immediately began to increase. EMS arrived and pt 02 had increased to 92 % on 15 L. Resident was transferred to (hospital) . This note was written by ADON A. During an interview on 7/22/24 at 12:48 p.m., LVN A said she had taken care of Resident #1 on 7/18/24 on the 6:00 a.m. to 6:00 p.m. shift. LVN A said normally she turned of Resident #1's tube feeding before breakfast. LVN A said she was very busy trying to get her finger sticks (blood sugar checks) and insulin administered, and she had people trying to get of bed. LVN A said she just forgot to turn off Resident #1's tube feeding. LVN A said she turned the pump off around 12:30 p.m., were her and CNA B went to perform incontinent care. LVN A said Resident #1 was still using the bathroom, so they (LVN A and CNA B) discontinued the care. LVN A said CNA B rounded on Resident #1 at approximately 1:30 to 1:45 p.m. LVN A said CNA B reported he was vomiting and didn't look right. LVN A said she went to the room and notified the ADON. LVN A said herself and the ADON suctioned him, called EMS. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/22/24 at 1:43 p.m., CNA B said she took care of Resident #1 on 7/18/24 on the 6:00 a.m. to 2:00 p.m. shift. CNA B said her partner working the hall with her had reported to her that Resident #1 had not wanted a breakfast tray. CNA B explained Resident #1 had a Tube feeding but was offered mechanically altered trays during the day. CNA B said she offered him a lunch tray but he declined it. CNA B said she told Resident #1 she would be back to pick up the tray and get him cleaned up. CNA B said when she returned at approximately 1:30 p.m. she was going to perform incontinent care but noticed the tube feeding was running. CNA B said she paused the Tube feeding before laying Resident #1 back because she had been taught to always ensure the tube feeding was paused before laying a resident with tube feeding back to perform incontinent care. CNA B said when she laid Resident #1 back and went to turn him on his side he started vomiting. CNA B said she then got LVN A and told her Resident #1 was vomiting. CNA B said LVN A said she had forgotten to turn off his Tube Feeding. During an interview on 7/22/24 at 2:00 p.m. LVN C said she was working on 7/18/24 but was the nurse for a different hall. LVN C said LVN A had not asked for any help or assistance until she was asked to retrieve oxygen for Resident #1 in the afternoon. LVN C said LVN A had not asked for any assistance before that time. LVN C said the nurses were good about helping each other and could not say why LVN A had not asked for help if she felt she needed it. LVN C said it was very important to ensure G-tube feedings were turned off at the ordered times because fluid could build up and increase a resident's risk of aspiration. During an interview on 7/22/24 at 2:20 p.m., LVN D said she was working on 7/18/24 but was the nurse for another floor. LVN D said LVN A never asked for help or assistance. LVN D said the facility was well staffed with 3 nurses, 5 nurse aids and 2 med aides. LVN D said there was not anything abnormal going on. LVN D said she could not say why LVN A had not ask for help as the everyone was worked as team. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview 7/22/24 at 2:31 p.m., the ADON said she was working on 7/18/24. The ADON said she received a text message from LVN A to come to Resident #1's room stat. Th ADON said she ran to the room and LVN A told me she realized when CNA B came to get her (LVNA) she had never turned off Resident #1's tube feeding. The ADON said Resident #1 was blue and his sat when she got in the room was 52 percent. The ADON said they continued intermittent suction and oxygen administration. The ADON said Resident #1 was still vomiting intermittently so she went to turn the resident on his side and noticed his abdomen was severely distended. The ADON said she also observed tube feeding was leaking from one of the three ports from the gastrostomy tube. The ADON said she opened the feed port in an attempt to aspirate contents, but the formula just came pouring out. The ADON said she sat a canister there to collect the feed pouring out of the port. The ADON said the canister collected somewhere between 400-500 mls of feed. The ADON said she continued to suction and provide oxygen and had gotten Resident #1's Spo2 up to 80 percent and by the time EMS arrived his Spo2 was up to 92 percent. The ADON said she had heard Resident #1's Sp02 had dropped again in the ambulance and that he was currently in the ICU intubated. The ADON said she questioned LVN A over the incident as to why she had not turned off the tube feeding. The ADON said LVN told her she just forgot and was trying to get her blood sugar checks and insulin administered. The ADON said she asked LVN A why she checked off the MAR that she had stopped the tube feeding for Resident #1 when she had not yet completed the task. The ADON said LVN A said she meant to turn it off and just forgot. The ADON said she told LVN A this is why you don't check/ sign something off before you have completed it. The ADON said had LVN A not checked off the task before the tube feeding was actually turned off it would have served as a reminder that the task had not been completed. The ADON said she sent LVN A home because she did not trust her mental state and knew she needed to be suspended . Record review of the hospital progress note dated 7/22/24 revealed Resident #1 was admitted to the hospital with diagnoses of acute respiratory failure and septic shock due to aspiration pneumonia and influenza b. The hospital progress note revealed Resident #1 was intubated but extubation would be attempted . Record review of the email from the Regional Dietitian to the DON, dated 7/23/24 stated If he [Resident #1] was on his current TF [tube feeding] and flushes for an additional 6.5 hours, this would have given him an extra: 585 cc of the TF formula and 487 cc of water from the flushes (total volume= 1072 cc). During an interview on 7/23/24 at 3:00 p.m., the Medical Director said he had to say that Resident #1 receiving his tube feeding for an additional 6 and half hours would increase his risk of aspiration. Record review of the facility policy and procedure dated 5/5/23, titled Nursing Policy and Procedures: Gastrostomy tubes, stated, .(2) The patient/resident that is fed by enteral methods receives appropriate treatment and services to restore oral eating skills and prevent complications of enteral feeding like aspiration pneumonia, diarrhea, vomiting, . complications: (1) Aspiration .(7) Death secondary to complications not addressed immediately. The Administrator was notified on 7/22/24 at 4:30 p.m. at that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided with the Immediate Jeopardy template on 7/22/24 at 4:43 p.m. The facility's Plan of Removal was accepted on 7/23/24 at 2:57 p.m., and included: (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Upon Resident #1's return or new admission of a resident that requires a tube feeding, the Director of Nursing/Designee will validate daily for 7 days that physician orders for tube feeding are being followed as written and continue to randomly validate weekly that physician orders for tube feeding are being followed as written. LVN A was suspended pending investigation on 7/18/24 and terminated post investigation on 7/22/24. The Director of Nursing/Designee will re-educate Licensed Nurses on 7/22/24 on following physician orders including start and stop times of tube feedings. The Director of Nursing/Designee will reeducate Licensed Nurses on 7/22/24 on assessing residents for complications related to tube feedings which includes the following: * Monitoring for nausea, vomiting, diarrhea and constipation * Gastric distention and bowel sounds * Monitoring for aspiration which may include adventitious breath sounds Licensed Nurses and Certified Nursing Assistants will be reeducated by the Director of Nursing/Designee by 7/23/24 on tube feeding management and prevention of tube feeding complications which includes: *Licensed Nurses may hold/pause feeding while ADL care is performed that requires the head of bed to be lowered *Certified Nursing Assistants will notify the licensed Nurse prior to performing ADL care that requires the head of the bed to be lowered to allow for the Licensed Nurse to pause/hold the feeding and resume the feeding once ADL care completed *Certified Nursing Assistants will not adjust the tube feeding, only licensed nurses Nursing Staff not receiving this education by 7/23/24 will receive prior to their next scheduled shift. The Director of Nursing/Designee will randomly interview a minimum of 3 nursing staff members weekly for 4 weeks to validate understanding and compliance with tube feeding management and prevention of tube feeding complications. Medical Director was notified of the incident and plan for improvement on 7/22/24. An Ad Hoc QAPI will be held on 7/22/24 to discuss the contents of this plan. On 7/23/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of LVN A's employee file confirmed she was suspended 7/18/24 and terminated on 7/22/24. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews on 7/23/24 from 11:00 a.m. to 2:50 p.m., with licensed nurses (LVN C, LVN D, LVNE, RN F, LVN G) who had worked on 7/22/24 and 7/23/24 on all shifts (6:00 a.m. to 6:00 p.m.) confirmed they had received in-services over the importance ensuring physician orders were followed related to tube feedings, not documenting task was complete before the task was complete, and monitoring for complications of tube feeding. The nurses said it was very important to ensure tube feedings were started/stopped as ordered by the physician because residents could receive to little or too much feeding if orders were not followed. The nurses stated that receiving too much feeding could place a resident at greater risk of fluid overload and aspiration. The nurses stated they would monitor residents on tube feeding closely for complications including nausea, vomiting, diarrhea, constipation, abdominal distention, bowel sounds, and signs of symptoms of aspiration. The nurses reported they would notify the physician immediately if any complications were observed. The nurses said they would also ensure prompt response to CNA requesting a tube feeding being paused in order to provide care as licensed nurses were the only ones that should hold, pause, stop or restart tube feedings. Interviews on 7/23/24 from 11:00 a.m. to 2:50 p.m., with CNAs and MAs (MA H, MA I, MA J, MA K, CNA L, CNA M, CNA N, CNA O, CNA P, CNA Q, CNA R, CNA S, CNA T, CNA U, CNA V, CNA W, CNA B) that worked on 7/22/24 and 7/23/24 on all shifts (6:00 a.m. to 2:00 p.m., 2:00 p.m.-10:00 p.m. and 10:00 p.m. to 6:00 a.m.) The CNAs said they would ensure a resident they were caring for with tube feeding would have their head elevated at all times at 30 to 45 degrees. The MAs and CNAs said if the head of the bed needed to be lowered to provide care they would notify the nurse to pause, stop or disconnect the feeding. The MAs and CNAs voiced that only a licensed nurse could touch a feeding tube pump. They said after they provided the care they would raise the head of the bed to 30-45 degrees and notify the nurse so they (nurses) could resume the feeding. The CNAs and MAs said they would notify the nurse immediately if a tube feeding resident had any change of condition, such as vomiting, diarrhea, a hard stomach, changes in breathing or any sign or symptom outside the residents normal. Record review of the Ad Hoc QAPI sign in sheet dated 7/22/24 confirmed and AD hoc QAPI had been held. During an interview on 7/2324 at 3:00 p.m., the medical director confirmed he had been notified of the IJ and attended the Ad Hoc QAPI via phone. Record review of the daily monitoring tool dated July 2024, for physician orders adherence as written for peg tubes was completed. During an interview on 7/23/24 at 3:20 p.m., the DON said the daily monitoring tool for physician orders adherence as written for peg tubes, would be utilized upon Resident #1's return to the facility or in the event a new resident with tube feedings was admitted to the facility. The DON said she would validate for daily times one week and then randomly every week that physician orders for tube feeding were being followed as written. The DON also said she would randomly interview nurses and aides (at least three staff weekly) for 4 weeks to ensure understanding and compliance with tube feeding management and potential complications of tube feeding. The DON said no staff would be allowed to work until they have received all in-services. During an interview on 7/23/24 at 3:30 p.m., the administrator said no nursing staff member would be allowed to return to work until they had completed all in- services. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/23/24 at 3:32 p.m., the Administrator was informed the IJ was removed; however, 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 that is not Immediate Jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on interview, and record review, the facility failed to ensure in accordance with professional standards of practices, the medical records on each resident were accurately documented for 1 of 4 residents (Resident #1) reviewed for accurate medical records. LVN A failed to accurately document on Resident #1's medical record when she documented Resident #1's tube feeding had been discontinued at 7:00 a.m. on 7/18/24. This failure could place residents receiving tube feeding at risk of increased complications of tube feeding. Findings included: Record review of the face sheet for Resident #1 indicated he was [AGE] years old, readmitted to the facility on [DATE] with diagnoses including HIV disease (human immunodeficiency virus) gastrostomy malfunction (malfunction of opening into the stomach from the abdominal wall, made surgically for the introduction of food) , dysphagia (difficulty or discomfort in swallowing) quadriplegia (paralysis of all four limbs) and unspecified protein-calorie malnutrition. Record review of the MDS dated [DATE] indicated Resident #1 sometimes understood others and sometimes made himself understood. The MDS indicated Resident #1 was cognitively intact (BIMS of 15). The MDS indicated Resident #1 was dependent on staff for eating, toileting, showering, dressing the upper and lower body, putting on and taking off of footwear, and personal hygiene. The MDS indicated Resident #1 had an active diagnosis of quadriplegia. The MDS indicated Resident #1 had a feeding tube and a mechanically altered diet during the 7 days look back period. The MDS indicated Resident #1 had received 51% or more of his total calories through tube feeding and 501 cc/day or more of his fluid intake by tube feeding daily during the seven days look back period. Record review of the care plan, revised on 6/4/24, indicated Resident #1 received tube feedings related to dysphagia. The care plan interventions included, elevate the head of bed 30-45 degrees during feeding and one hour after; check residual if residual 150 ml or less reinsert volume into stomach and continue feeding-If greater than 150 ml hold feeding and notify physician; and monitor for signs/symptoms of tube feeding intolerance. Record review of the active physician order dated 2/21/24 revealed Resident #1 was to be administered enteral feeding (Enteral nutrition refers to any method of feeding that uses the gastrointestinal (GI) tract to deliver nutrition and calories) with Jevity 1.5 at 90 cc/hr from 5:00 p.m. to 7:00 a.m. via pump per G-tube with a 75 cc water flush via the G-tube per hour. Record review of Resident #1's MAR for 7/18/24 indicated Resident #1's tube feeding had been stopped at 7:00 a.m. The MAR was electronically signed by LVN A. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/22/24 at 12:48 p.m., LVN A said she had taken care of Resident #1 on 7/18/24 on the 6:00 a.m. to 6:00 p.m. shift. LVN A said normally she turned off Resident #1's tube feeding before breakfast. LVN A said she was very busy trying to get her finger sticks and insulin administered and she had people trying to get out of bed. LVN A said she just forgot to turn off Resident #1's tube feeding. LVN A said she turned the pump off around 12:30 p.m., were her and CNA B went to perform incontinent care. LVN A said Resident #1 was still using the bathroom, so they (LVN A and CNA B) discontinued the care. LVN A said CNA B rounded on Resident #1 at approximately 1:30 to 1:45 p.m. LVN A said CNA B reported he was vomiting and didn't look right. LVN A said she went to the room and notified the ADON. LVN A said herself and the ADON suctioned him, called EMS. LVN A said she documented the tube feeding had been discontinued at 7:00 a.m. because she had intended to turn off the feed but just forgot. During an interview 7/22/24 at 2:31 p.m., the ADON said she was working on 7/18/24. The ADON said after Resident #1 was sent to the hospital she questioned LVN A about the incident and asked her why she had documented the tube feeding was discontinued at 7:00 a.m. The ADON said LVN A told her she documented the task was complete because she was going to do it and just forgot. The ADON said she told LVN A that was exactly why she should not have documented the tube feeding was discontinued because had she not documented it was done, the work log would have reminded her the task was not compete. During an interview on 7/22/24 at 2:05 p.m. The DON said LVN A should not have documented Resident #1's tube feeding was stopped at 7:00 a.m. if she had not completed the task. The DON said the way the orders were entered were to remind and ensure that nurses did not forget to start and stop the tube feeding at the ordered times. The DON said LVN A charting she had completed the task, when she had not was part of checks system to ensure nurses did not forget to perform important tasks, such as stopping the tube feeding for Resident #1. Record review of the facility policy and procedure , dated 5/23/23, titled Nursing policy and Procedures, Documentation Licensed Nursing, stated .documentation pertaining to patient/resident will be recorded in accordance with regulatory requirements .the qualified nursing staff notes the time and date and dosage of all medications and treatments at the time they are administered and initials the note on the medication/treatment record .if a scheduled medication is withheld or not given as ordered, the nurse documents this and lists the reason for the patient/ resident not receiving the medication .