STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155199	A. BUILDING _____ B. WING _____	C 10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE PARK VILLAGE	776 N UNION ST WESTFIELD, IN 46074

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00445223. Complaint IN00445223 - Federal/state deficiencies related to the allegations are cited at F693. Survey date: October 18, 2024 Facility number: 000106 Provider number: 155199 AIM number: 100266390 Census Bed Type: SNF/NF: 80 SNF: 3 Total: 83 Census Payor Type: Medicare: 4 Medicaid: 35 Other: 44 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 25, 2024.	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 693		

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

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F 693	Continued From page 1 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a resident with continuous feeding through a Jejunostomy tube (J-tube) received the ordered amount of nutrient formula at the correct rate in the ordered time frame for 1 of 2 residents reviewed for enteral feedings. (Resident B) The deficient practice was corrected on 10/15/24, prior to the start of the survey, and was therefore past noncompliance. Findings include: During an interview, on 10/18/24 at 8:42 a.m., the Executive Director indicated Resident B had received a total of 1000 ml (milliliters) of enteral feeding over a four (4) hour period via her J-tube. During an observation, on 10/18/24 at 1:29 p.m., the feeding pump was assessed. The Director of Nursing, Executive Director, Corporate Support	F 693	Past noncompliance: no plan of correction required.	

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Nurse and Regional Vice President of Operations were present. The history was not assessable as the pump had been disconnected from a power source since 10/14/24. The Executive Director indicated they had attempted to access the pump memory but kept receiving an error message. It was noted when the power was restored to the pump it had shown a rate of 400 milliliters per hour (ml/hr.). At that time, the Executive Director indicated that was the factory reset. The pump did not go above 400 ml/hr.

The clinical record for Resident B was reviewed on 10/18/24 at 11:13 a.m. The diagnoses included, but were not limited to, multiple sclerosis, quadriplegia, encounter for attention to tracheostomy, and coronary artery disease.

A physician's order, dated 7/4/24, indicated to give Osmolyte 1.5 (nutritional formula) at 45 milliliters per hour via J-tube (tube placed through the skin of the abdomen into the midsection of the small intestine).

A facility document, untitled and dated 10/13/24, indicated the night shift nurse (LPN 1) had informed the writer (RN 3) the pump was not working. It said system failure. RN 3 checked the pump and confirmed it was not functioning properly. She called tech support, and a technician was to call back. She went and retrieved a new feeding pump, replaced the old pump, and set the flow rate on the new pump to 45 ml/hr for the feeding and 45 ml/hr. for the water flush. She noted she had double checked the rates with the order. She noticed when changing rates, the default rate of infusion was 400 ml/hr. The feeding pump was primed and infusing by 9:00 a.m., on Sunday morning

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(10/13/24). She was in the facility until 10:00 p.m. on Sunday (10/13/24) and did not hear of any concerns with Resident B or the feeding pump. She had called the company, using the number on the side of the pump, at about 7:00 a.m. that morning and the company returned the call at around 7:30 p.m. that evening. LPN 1 received the call and since the pump was running, he told them they were no longer needed.

A facility document, untitled and dated 10/15/24, indicated LPN 1 had gone to Resident B's room at 5:00 a.m., to give medication and change the tube feeding. He turned the pump off, removed the old container, hung the new container, turned the pump on, kept the previous settings, and primed the line. During that time, he checked for placement and residual, administered the resident's medication, and then connected the J-tube to the feeding pump and started the machine. He then left the room to tend to a resident who was attempting to get out of bed. He did return to Resident B; she wanted to see him. He readjusted her in bed, and she began to cough. He suctioned her, offered her a drink of water, and then left the room. He checked on her once more. She informed him she was warm and wanted the sheet off. He did as she requested and left the room. She was not in distress. He then gave report to the oncoming shift and left the facility. Additional information added to the statement indicated the bottle of feeding he removed was dated for the previous day (10/13/24) and when he checked on the resident around 6:20 a.m., that morning the formula was at the top of the bottle, where it would be, if it was infusing at the correct rate.

A facility document, dated 10/15/24, indicated

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Housekeeper 6 entered the room on 10/14/24 at 7:24 a.m., and left a cup if ice water. The resident was sleeping. She did not hear the feeding tube machine alarming.

A facility document, untitled and dated 10/15/24, indicated Staff 5 entered Resident B's room on 10/14/24 at 8:59 a.m. She was in the room for less than a minute. Resident B signaled she needed assistance. Staff 5 did not notice if the resident was in distress. She then went and informed RN 2 the resident required assistance. She did not hear the feeding tube alarming.

A facility document, untitled and dated 10/15/24, indicated CNA 7 responded to Resident B's call light at 9:00 a.m. The resident requested a drink of water and CNA 7 noticed yellow emesis on her face and gown. She informed Resident B she needed to get the nurse. She informed the nurse she was needed in the resident's room; the resident had emesis on her face and gown and the pump was beeping. The nurse went to the room looked at the pump, took the resident's vital signs and informed the CNA she would be back. Another CNA had reported to the room; and both CNAs cleaned up the resident.

A facility document, untitled and dated 10/15/24, indicated CNA 8 was picking up room trays on the hall around 8:30 to 9:00 a.m. She heard Resident B call, so she answered and found the resident had yellow emesis on her gown and the pump was beeping. CNA 8 cleaned the resident's face and informed the nurse. She did observe the nurse to enter the room and followed to see if additional assistance was needed. After the nurse had assessed the resident's vital signs and checked the feeding pump, CNA 8 and another

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CNA cleaned the resident and changed her gown.

A facility document, untitled and undated, indicated RN 2 upon entry to Resident B's room noticed yellow fluid emesis and the feeding pump was completely infused. She turned off the pump and staff provided care for the resident while she notified the provider on call of the current situation. The bottle of feeding formula was dated for that morning by the previous shift. She received new orders. The scheduled medications and as needed medications were given. She suctioned the resident's tracheostomy and noted a small amount of white phlegm. She assessed the vital signs; the resident's heart rate and respirations were increased. She notified the on-call provider and new orders were received. The medication was provided. She noted the resident's spouse was present in the room. A second nurse came to the room to check the resident's condition. There was no improvement, and the residents pulse oximetry indicated her oxygen saturation was down to 58 percent. The second nurse contacted the physician. Physician 4, who was present in the facility, came to the resident's room and placed the artificial manual breathing unit on the tracheostomy and provided breaths until the emergency response team arrived.

A hospital document, dated 10/14/24, indicated the resident was seen at 11:38 a.m. She presented to the hospital, via EMS, to be evaluated for shortness of breath and decreased oxygen saturation. EMS reported increased shortness of breath and decreased oxygen saturation after patient received tube feedings. There was concern for aspiration. Upon arrival the patient was hypotensive (low blood pressure),

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had a Glasgow Coma score of 3 (lowest score) and her oxygen saturation level was about 50 percent. The resident had diffuse cyanosis (blue coloring), did not respond to external stimuli, her pupil response was sluggish, and white frothy sputum was noted at the tracheostomy.

During a telephone interview, on 10/18/24 at 8:50 a.m., the county coroner's office staff member indicated the final cause of death report would not be available for 4-6 weeks. They did not know the cause of death and lab reports were pending on fluid in the resident's lungs. She indicated Resident B had about 200 ml of fluid in her "belly".

During a telephone interview, on 10/18/24 at 11:28 a.m., LPN 1 (the night nurse) indicated he went to the room, around 5:00 a.m., to change the feeding set and administer medications. He hung the new bottle of feeding and set machine to prime the line. He then administered medication with 30 milliliters (ml) flush before and 30 ml flush after. He indicated medications were given via the gastronomy tube (g-tube, a line inserted into the stomach), but the feedings were given via j-tube and the ports are labeled as such. He flushed the j-tube with 60 ml water and connected the j-tube to the pump. The setting was 45 ml/hr for the feeding and he did not change the setting as it was already programmed into the machine. He then left the room. Everything was running fine. He checked on the resident again, that morning, at "6 something". The CNA told him the resident wanted him. The resident wanted to be adjusted in the bed. She was alert and voicing her needs, she was also coughing. LPN 1 suctioned her tracheostomy once, at that time. He indicated coughing was

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usual for her. Once he finished suctioning her tracheostomy, he left the room. LPN 1 indicated she was breathing "ok, all was fine." He did return to the room once more at about 6:15 a.m. He wanted to check if she was still coughing, sometimes she did and she would have mucus come out of her mouth. The pump was fine, it was almost full, it was running fine, and resident was breathing fine. She had no signs of distress.

During an interview, on 10/18/24 at 11:51 a.m., RN 2 indicated she passed Resident B's room many times and had peeked in to ensure the resident was okay and had her blow tube for the call light. She had entered the room because the resident had told her she was thirsty and wanted a drink of water. RN 2 indicated Resident B would only take sips, enough to "wet her whistle". RN 2 then left the room. She indicated she would administer Resident B's medications last because it did take a little more time, and she did not want to delay the other residents' medication administration. RN 2 indicated she was at the nursing station working when the resident's call light came on. The CNA, while on the way to the room, indicated the pump was beeping. RN 2 responded. The pump was sounding, and the infusion had completed. She immediately turned off the pump because there was air in line. The resident had emesis (vomited) a moderate amount. It was not a lot but enough to be on her chin, chest and tracheostomy dressing. It was yellow in color. The resident never forcefully vomited, it just "rolled out of her mouth". She changed the tracheostomy dressing and collar. While the CNA was cleaning up the resident, RN 2 returned to the nursing station and contacted the provided to notify them of the emesis. She had not yet assessed lung sounds; she was going

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to after she administered a breathing treatment. RN 2 indicated she did administer a breathing treatment and suctioned the tracheostomy. She noted a small amount of white phlegm on the first suction pass and nothing on the second, so she stopped suctioning the resident. She did assess the resident's lung sounds and found them to be diminished. RN 2 indicated this was normal for the resident since her return from the hospital in September (2024). The resident had been on a ventilator for two weeks and returned to the facility on three liters of oxygen through her tracheostomy. The resident had never required oxygen continuously prior to the September hospitalization. They had tried to titrate the oxygen to two liters, but the residents blood oxygen levels would drop so she had to be on three liters. RN 2 indicated she felt like she was going through the same situation she went through in September when the resident's oxygen saturations had dropped, and she had to be sent to the hospital.

During a telephone interview, on 10/18/24 at 3:06 p.m., Physician 4 indicated the feeding to the small bowel would continue to slide south (downwards) to the small bowel. There would not be a significant issue with nausea. The worst case a little bit of feeding could slide back to the stomach, but the majority would go to the small bowel. He indicated he felt Resident B had been living at the end of her life for the past 2 years. She had very little reserve from day to day and the facility team cared for her and maintained her life. Recently she had a similar event and went to the hospital. She returned to the facility, and he did see her. He felt she had no "reserve".

During an interview, on 10/18/24 at 3:35 p.m., the

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policy for following physician's orders was requested. The Corporate Support Nurse indicated the information would be included in the medication administration policy. It was standard practice to follow physician's orders and to monitor residents throughout the day.

A current facility policy, titled "General Dose Preparation and Medication Administration," dated as last revised 4/30/24 and received from the Executive Director on 10/18/24 at 3:39 p.m., indicated "...Verify each time a medication is administered that is...at the correct rate...."

The deficient practice was corrected by 10/15/24 after the facility implemented a systemic plan that included the following actions: The facility investigated the incident involving Resident B, educated the staff on enteral feeding protocol, use of enteral pumps, and nursing assessments for residents with emesis and enteral feedings. Audits were initiated for other residents receiving enteral feedings to ensure they were getting the correct flow rate and rates were checked hourly. The facility initiated two (2) nurses were to sign a validation for the correct flow rate when a new bottle was initiated. Nursing managers began to audit residents with enteral feeding orders for the correct flow rates and correct formula daily. Enteral nutrition and Enteral pump skill validation tools were completed.

This citation relates to Complaint IN00445223.

3.1-44(a)(2)