STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105175	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plantation Nursing & Rehabilitation Center	4250 NW 5th St Plantation, FL 33317

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review and interviews, the facility failed to monitor the temperatures for 2 of 4 sampled residents, Resident #43 and Resident #98, who were being treated with an antibiotic for respiratory infection, as evidenced by no temperatures were documented.The findings included:Review of the facility policy titled Vital Signs revised on 04/28/24, documented in part: Vital signs are indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation, and pain. Policy Explanation and Compliance Guidelines: 4. Vital signs should be obtained at least in the following circumstances: c. daily for a resident receiving skilled services per physician order. At least weekly for resident's receiving custodial care, or nonskilled services. When residents' general condition changes. Vital signs should be obtained by the nurse when administering certain medications or monitoring for effectiveness of medication or therapies. Record review revealed that Resident #43 was admitted to the facility on [DATE]. The quarterly comprehensive assessment dated [DATE] documented a Brief Interview Mental Status score of 14 on a 0-15 scale, indicating no cognitive impairment. 1. Record review revealed a progress note dated 06/24/25 written by the attending physician documented she saw Resident #43 and the resident had a persistent cough and shortness of breath. Photographic Evidence Obtained.Review of a physician order dated 06/24/25 for Resident #43 revealed an order instructing staff to administer Levaquin(antibiotic) 500mg daily for 7 days for cough. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the vital signs for Resident #43, revealed that the last documented temperature was on 05/19/25 at 6:24 PM. During a brief conversation with Director of Nursing (DON) on 06/26/25 at 12:50 PM, The DON was asked to show where the staff are documenting temperatures for Resident #43. The DON looked in the resident's record. After looking in the record, the DON stated I don't see any temperatures documented prior to 05/19/25.During an interview on 06/26/25 at 12:53PM, Staff J, Registered Nurse (RN), when asked where they document the vital signs for a resident, Staff J went to the computer and as viewing a resident's record she stated, Some residents have an order on the Medication Administration Record (MAR) to document vital signs every shift, otherwise it's documented in the vitals tab in the resident's record. When asked where they documented the vital signs for Resident #43, Staff J stated, under the vital signs tab. When asked where the vital signs obtained today for Resident #43 were documented, Staff J, while looking at the resident's record, stated right here. When asked, according to what was documented, when was the last time Resident #43's temperature last taken, Staff J stated, on 05/19/25. She was asked if the resident is currently being treated for a respiratory infection and she said yes. When asked what vital sign is important to check when a resident is on an antibiotic, Staff J stated, The temperature. When asked what Resident #43's temperature was today, she stated I didn't check it. Review of a progress note dated 06/25/25 at 12:37 PM, written by Staff J, documented that Resident #43 was on Levaquin [antibiotic] for Pneumonia with no fever. Further review of the resident's record did not reveal a documented temperature taken on the Resident #43 on 06/25/25. 2. Record review revealed that Resident #98 was admitted to the facility on [DATE]. Review of the quarterly comprehensive assessment dated [DATE] documented a Brief Mental Status Interview (BIMS) score of 09 on a 0-15 scale, indicating severe cognitive impairment. There were documented medical diagnoses of history of Pleural Effusion (fluid in the lungs and chest) and Acute Asthma (airway become inflamed). Review of a progress note dated 06/20/25 written by the attending physician revealed that she saw and examined Resident #98 and the resident continues to have coughing and wheezing. The physician's plan was for the resident to see a pulmonologist and for staff to continue administering breathing treatments as needed to the resident. A second progress note written by staff, dated 06/21/25 at 6:30 PM, revealed that Resident #98 had a productive cough and complained of a sore throat. Review of a progress note dated 06/22/25, indicated that the attending physician gave an order instructing staff to administer Levaquin (antibiotic) 750mg daily for 7 days to treat pneumonia. Review of a progress note dated 06/25/25 at 1:02 PM, Staff J, RN, documented Resident #98 was taking Levaquin 750 mg for Pneumonia with no fever or allergic reaction. There was no documentation by Staff J of her checking the resident's temperature on 06/25/25. Review of the vital signs documented for Resident #98 indicated that the last temperature checked on this resident was on 06/17/25. Photographic Evidence Obtained. 3. Record review revealed Resident # 66 was admitted on [DATE] with diagnoses that included Cardiac Arrest, Respiratory Failure with unspecified Hypoxia, Tracheostomy status, Anoxic Brain Damage, and Persistent Vegetative state. Review of the annual Minimum Data Set (MDS) assessment, dated 06/02/25, for Resident #66, under Section C of the Brief Interview of Mental Status (BIMS) score was disabled by questions B0100 and C0100, revealing a zero (0), indicating severe cognitive impairment and the resident is rarely/never understood. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders for Resident #66, dated 05/08/25, revealed an order for: Enalapril Maleate oral tablet, 2.5 milligram (mg), give 2.5 mg via g-tube two times a day for hypertension, hold for systolic blood pressure (BP) less than 90. Review of a nursing care plan goal dated 10/24/24 revealed Resident #66 is ventilator dependent related to perfusion deficit. The interventions for Resident #66 included the following: remain hemodynamically stable through the review date, remain free of complications related to decreased cardiac output, pneumothorax, subcutaneous emphysema, decreased renal perfusion, increased ICP, and hepatic congestion through the review date. Review of the June 2025 Medication Administration Record (MAR) revealed no documented BP during the 8:00 AM and 4:00 PM for the Enalapril administrations on 06/08/25, 06/09/25, 06/10/25 and 06/11/25. There were check marks and nurses' initials indicating Enalapril was administered at those dates and times by staff Nurses. In an interview with the Assistant Director of Nursing (ADON) on 06/24/25 at 9:47 AM, who when asked if BP parameters are documented in resident's MAR, responded, BP including other vital signs are documented in the provided spaces in MAR. He stated that staff Nurses document the vital signs, and bp parameters in MAR for antihypertensive medications. An interview was conducted with Staff Y, Registered Nurse (RN), on 06/25/25 at 04:00 PM, who has been working in the facility for a year, and who when asked what check marks on the top of nurse's initials mean parallel to the medication on MAR, responded, The medication was administered by the nurse with the initials present on MAR. The check mark indicated the medication was administered. An interview was conducted with Staff J, RN, on 06/25/25 at 4:10 PM, who when asked if the medications were administered to Resident #66 on the above dates, responded, Upon checking the e-MAR, it revealed an 0 indicating the medications were administered on the above dates. She added that when a medication was not administered, nurses write the reason on the progress notes. Staff J checked Resident #66's progress notes and stated there were no written notes indicating the medication was not administered on the dates mentioned. She also checked Resident 66's admission date which she stated was in 2023. Saff J stated Resident #66 was readmitted on [DATE], indicating the resident has not left the facility since then, so there was no reason why the Enalapril medication was not administered. She verified that the nurses did not document the vital signs and BP in the MAR, when the medication was administered on the above dates.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation, interview and record review, the facility failed to ensure that it followed the physician's order for splints in order to prevent further decline in range of motion (ROM) for 2 of 2 sampled residents observed, Resident #53 and Resident #44.The findings included:Review of the facility policy, titled, Policy and Procedure - Range of Motion (ROM) Splints, Braces, Orthotics, provided by the Director of Nursing (DON), revised 10/26/23, documented in the Policy Statement: Residents identified as a risk for contractures will have ROM program .which includes the programs provided to prevent contractures and keep joints as limber as possible . Splints, braces and orthotics will be applied according to manufacturer's instructions and/or instructions from physical and occupational therapy .Purpose: To maintain a resident's ability to move a joint through its normal range of movement and perform activities of daily (ADL). To prevent pain, discomfort, swelling and stiffness when joint movement is limited or contracted. To prevent contractures and to provide comfort and support for a joint and prevent pain in an already deformed/contracted, weak joint Splints/Braces Orthotics .Nursing staff will: Prepare joint for splint - proper alignment, ROM, warm water soak when indicated. Always inspect skin carefully before application and after removal. Be gentle and move slowly when applying devices .Caution to not pull strap too tight. Allow your fingers to comfortably fit in between device and skin. Report all skin problems, redness, swelling, pain or changes in fit to nurse and therapy immediately. Follow the device schedule according to therapy instructions. Store splints in a consistent place away from heat sources. Follow manufacturer's instructions for cleaning. Document according to facility protocol. Follow applications of splints, braces and orthotics according to a manufacturer's Physical and Occupational Therapy instructions .Record review revealed Resident #53 was originally admitted to the facility on [DATE] with diagnoses which included Cerebral Palsy, Traumatic Brain Injury and Orthostatic Hypotension. She had a Brief Interview Mental Status (BIMs) score of 00, indicative of severe impairment. On 02/01/25 the physician's order documented for Adaptive Equipment: Right Blue comfy elbow and Bilateral (Right and Left) Pink [NAME] hand splints to be worn from AM care to hours of sleep as tolerated. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #53's care plan initiated 06/12/22 indicated Focus: Child has self-care deficit/inability to use call bell. She requires total assistance with bathing, hygiene, dressing, feeding, toileting, positioning and transfer related to Subdural Hematoma, Traumatic Cerebral Edema, Brain Herniation status post motor vehicle accident. She was admitted with multiple fractures including left clavicle, thoracic spice, Pubis Sacrum, status post bilateral Strokes, (Craniotomy 06/12/22, impaired functional range of motion to all extremities (Hypotonia). Interventions: Apply right comfy hand splint, left [NAME] splint and right elbow comfy to be worn after AM care until hours of sleep and with therapy Goal: Child's needs will be anticipated, and will be kept clean, dry, and comfortable on a daily basis thru next review date.On 06/23/25 at 10:10 AM during an observation conducted of Resident #53, it was observed the resident had bilateral hand contractures. Resident #53 was observed as not having her ordered elbow splints on and in place, nor her bilateral hand splints on and in place. There were no splints or braces noted at the bedside. Photographic Evidence Obtained. On 06/23/25 at 3:16 PM, during a second observation conducted of Resident #53, the resident was observed again with no ordered elbow splints in place and no bilateral hand splints in place. There were none noted at the bedside.On 06/24/25 at 10:12 AM during a third observation conducted of Resident #53, the resident was again observed with no ordered elbow splints on and no bilateral hand splints on and none noted at the bedside.On 06/24/25 at 1:39 PM during a fourth observation conducted of Resident #53, she was now observed sitting up in her wheelchair in her room and she did not have her ordered elbow splints on, no bilateral hand splints on, and still none noted at the bedside.On 06/25/25 at 11:18 AM during a fifth observation conducted of Resident #53, she was observed resting in bed in her room. The observation revealed no ordered right elbow splint on, no bilateral hand splints on, and still none noted at the bedside.On 06/25/25 at 11:15 AM during an interview conducted with Staff Q, Physical Therapist (PT), who was Certified in Neurodevelopmental treatment (C/NDT), and who had previously worked with this resident in the past, she stated that Resident #53 had not displayed any behaviors that would prevent her from providing care to the resident.On 06/25/25 at 11:45 AM during an interview conducted with Staff O, Certified Nursing Assistant (CNA), she also indicated that Resident #53 had not exhibited any behaviors, to her knowledge, that would prevent her from providing care to the resident. Staff O also stated that the resident's two (2) hand splints and a right elbow splint, were kept in her closet, across from her bed, down inside of a bin. Staff O acknowledged that Resident #53 was not currently wearing any splints to her hands or right elbow at the time. Staff O stated the last time she recalled seeing Resident #53 wearing her splints was during the last week, Friday, June 06/20/25. Computerized record review of the Treatment Administration Record (TAR) for Monday 06/23/25 and for Tuesday 06/24/25, indicated that Resident #53's bilateral hand splints and her right elbow splint, had been checked and initialed as if they had been put on and in place, for both days. Observation revealed they had not been placed on the resident.During an interview conducted on 06/25/25 at 12:37 PM with Staff P, Registered Nurse (RN), she indicated Resident #53 had not exhibited any behaviors, that would prevent her from providing care to the resident. Staff P also acknowledged that Resident #53 had not currently been wearing any splints to her hands or right elbow. She added that the last time she saw the resident wearing her hand splints and right elbow splint was last week. On neither of the above two (2) days during this survey, had nursing or therapy staff been observed as having placed Resident #53's bilateral hand splints, or her right elbow splint on. On 06/25/25 at 11:25 AM, an interview was conducted with Staff R, Occupational Therapist (MOTR/L), who indicated Resident #53 had not exhibited any behaviors, while she was providing care to her on Wednesday 06/18/25 last week. She stated the resident was agreeable to treatment with no issues. Staff R stated the resident was not currently wearing any splints to her hands or right elbow. She stated she had not worked with Resident #53 for the past two (2) days. Staff R acknowledged there were no entry notations to document that Resident #53 had been seen by OT on Monday 06/23/25 or on Tuesday 06/24/25. Staff R stated the last time Resident #53 was documented as having had her hand splints and right elbow splint on was on Thursday 06/19/25, one (1) week ago. On 06/25/25 at 11:49 AM, an interview was conducted with the Director of Therapy, who stated Resident #53 has not exhibited any behaviors that would interfere with her providing care to her. The Director stated the resident was not currently wearing any splints to her hands or right elbow now, but she did not know why she was not wearing them. She stated the last time she recalled Resident #53 wearing them was last week. There was no documentation reviewed in the past week or longer to indicate that there were any behaviors

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident #44 was readmitted to the facility on [DATE] with diagnoses of Hemiplegia, Adult Failure to Thrive, and Parkinson's Disease. Review of the Significant Change Minimum Data Set (MDS) assessment showed Resident #44 has a Brief Interview of Mental Status (BIMS) score of 06, indicating severe cognitive impairment. In an observation conducted on 06/24/25 at 9:00 AM, Resident #44 was observed in the room sitting on a chair. Closer observation showed that his left hand was very contracted with no splint in place. In an observation conducted on 06/24/25 at 10:40 AM, Resident #44 was observed in the room sitting on a chair. Closer observation showed that his left hand was very contracted with no splints in place.In an observation conducted on 06/24/225 at 12:35 PM, Resident #44 was noted in the room sitting on a chair. Closer observation showed that his left hand was very contracted with no splint in place. In an observation conducted on 06/24/25 at 2:30 PM, Resident #44 was noted in the room sitting on a chair. Closer observation showed that his left hand was very contracted with no splint in place. In an observation conducted on 6/24/2025 at 3:00 PM Resident #44 was noted in the room sitting on a chair. Closer observation showed that his left hand was very contracted with no splint in place. In an observation conducted on 06/25/25 at 9:00 AM, Resident #44 was noted in the room sitting on a chair. Closer observation showed that his left hand was very contracted with no splint in place. Review of the care plan dated 06/12/25 showed Resident #44 is risk for skin breakdowns related to impaired mobility. Resident #44 wears a left-resting hand splint. In an interview conducted on 06/24/25 at 4:20 PM with the Rehab Director, she stated that Resident #44 has a left-hand splint, which is placed on during the day and tolerated. It is usually during the day hours when the morning shift starts until before the morning shift is over. Nursing usually documents if the splint is provided in the Point Click Care (PCP) Electronic System. Resident #44 experiences contractions in his fingers, and the splint helps maintain skin integrity, ensuring that his fingers do not dig into the palms. According to the Rehab Director, it is usually the Certified Nursing Assistants who oversee the splint orders. In an interview conducted on 06/24/25 at 4:29 PM with Staff A, Licensed Practical Nurse (LPN), stated the splint is placed on Resident [#44] by the nurse or the Certified Nursing Assistant that is assigned to the resident. It is usually placed daily, right after morning care. When asked if it is documented anywhere in the Electronic Record, she said 'no'. She stated that she worked the morning shift today, and when asked if she had placed the splint on Resident #44 that morning, she replied, 'no'.

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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. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations interviews and record reviews, the facility failed to follow the professional standards of care, as evidenced by failure to verify gastrostomy placement, for 1 of 5 sampled residents on tube feedings, Resident #25. The findings included: Review of the American Society for Parenteral and Enteral Nutrition (ASPEN), Safe Practices for Enteral Nutrition Therapy revealed one of the recommendations to prevent aspiration related to enteral nutrition, is to verify that feeding tube is in proper position before initiating feedings. https://aspenjournals.onlinelibrary.[NAME].com/doi/full/10.1177/0148607116673053.Review of the facility's policy titled, Care and Treatment of Feeding Tubes, with a revision date of 04/01/24, revealed the facility is to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. Additionally, license nurses will monitor and check that the feeding is in the right location, and that tube placement will be verified before beginning a feeding and before administering medications (6). Record review revealed Resident # 25 was admitted on [DATE] with diagnoses that included Tracheostomy Status, Unspecified effects of Drowning and non-fatal submersion, Dysphagia, Gastrostomy Status, Gastroesophageal Reflux Disease (GERD), Respiratory Disorders, and Anoxic Brain Damage.Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] under Section C revealed the Brief Interview of Mental Status (BIMS) score for Resident #25 was disabled by questions C0100, indicating an attempt to conduct interview with the resident resulted to code 0 (zero), or a no, which indicated the resident is rarely/never understood. Review of the physician orders revealed the following: on 05/21/25, Enhanced Barrier Precautions (EBP) as indicated for percutaneous endoscopic gastrostomy (PEG)and tracheostomy tubes, every shift; on 04/29/25, enteral feed four times a day, to give 195 milliliters (mL) of Peptamen [NAME] 1.5, run over one hour per pump via gastrostomy (g) tube, and from 8:00 PM to 6:00 AM, give 105 ml/ hour for 10 hours of Peptamen [NAME], 1.5 overnight, to be infused via g tube by pump. Additional physician order revealed feeding pump may be turned off for care and treatment every shift. Review of the nursing care plan revealed Resident #25 is at risk for aspiration secondary to gastrostomy (g) tube dependency, tracheostomy placement, and diagnosis of Gastroesophageal Reflux Disease (GERD). Review of the nursing care plan interventions included the following: assess bowel sounds every shift; check gastrostomy (g) tube for patency and placement before administration of medication and flushes; and check g tube for patency before administration of feeding and flushes. An observation was conducted on 06/24/25 at 10:44 AM with Staff H, Licensed Practical Nurse, LPN, who stated she would give the feeding to the resident. Staff H put on yellow gown after performing hand hygiene, went straight to the resident who was sitting on a wheelchair, exposed the resident's G-tube and connected the ends of resident's G-tube to the end of tube feeding connector. Staff H did not disinfect the ends of both G-tube ports and the tip of the tube feeding. Staff H did not check for G-tube placement or assess Resident #25's bowel sounds.An interview was conducted with Staff H on 06/24/25 at 4:53 PM, who when asked what nurses do before administering feeding in a G-tube, replied, I should check the placement. She added that she only checks the G-tube placement in the morning and not during the next tube feedings. When asked if that was the facility's policy, she responded, I always check it only in the morning.An interview was conducted with Staff H on 06/26/25 at 3:04 PM, who when asked why she did not check the G-tube placement before administering the feeding to this resident, responded, I did not check the G-tube placement before administering the feeding, because when I do it in the morning, I do not need to check it again it during the next feedings. When she was asked how often she gets in-service training for G-tube care, she responded, I do not remember the dates. When asked if she documented any G-tube feedings in the progress notes, she responded, No, I do not write when I check for G-tube placement and residual in the progress notes. She added that there is no section in the Medication Administration Record (MAR) for her to write for any G-tube placement checks for residual and placement before medication and feeding administration.An interview was conducted with the Assistant Director of Nursing (ADON) on 06/26/25 at 03:13 PM regarding the care of a resident with a G-tube, who responded, I check for residual volume, and G-tube placement before feedings and medication administration. He added that it is standard practice. and he does not know if nurses in the facility are doing them. When the ADON was asked if the standards of practice for checking G-tube placement and residual volume before administering medications are included in the physician orders, he responded, I have not seen those orders for residents with G-tube feedings. He added that he writes events

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow their policy for proper tracheostomy care for 1 of 3 resident (Resident #23), and failed to perform pre and post respiratory assessment for 1 of 3 sampled residents reviewed for tracheostomy care (Resident #695); failed to obtain written and care treatment orders for 1 of 5 sampled residents, Resident #53; failed to obtain oxygen therapy orders for 1 of 5 sampled residents, Resident #84; failed to perform pre and post assessments including vital signs for 1 of 5 sampled residents, Resident#695; and failed to properly store and maintain respiratory equipment and supplies for 3 of 5 sampled residents reviewed for oxygen therapy, Resident #31, Resident #6, and Resident #25.The findings included:Review of the policy titled, Tracheostomy Care-Suctioning with a revision date of 03/27/24, revealed the facility will ensure that residents who need respiratory care, including tracheal suctioning are provided such care consistent with professional standards of practice. The procedures included the following: raise the head of bed to 30-45 degree angle, using sterile technique, open the suction catheter kit and put on sterile gloves; consider the glove on your dominant hand sterile, and the non-dominant hand clean; using the non-dominant (clean) hand, pour the normal saline solution into the disposable sterile solution container; remove the suction catheter from it's wrapper with dominant (sterile) hand, coiling it to keep it from touching a non-sterile object; and document procedure and any significant findings. Review of policy titled, Respiratory Care Manual with an effective date of 07/18, revealed the following: respiratory equipment shall be changed as scheduled to control bacterial inoculation of respiratory therapy equipment; oxygen tubing is to be changed every Monday and as needed if grossly soiled (8); all equipment shall be labelled with name, date and therapist's initials (11). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Purpose: Medical Equipment Cleaning, Storage, Distribution and Repair, revealed the Respiratory Department (if appropriate) will be responsible for all respiratory equipment distribution.1. Record review revealed Resident #23 was admitted on [DATE] with diagnoses that included Arnold Chiari Syndrome with Spina Bifida and Hydrocephalus, Severe Intellectual Disabilities, Respiratory Failure and Anoxic Brain Damage. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], under Section C of the Brief Interview of Mental Status (BIMS) score for Resident #23 revealed an attempt to conduct an interview resulted to a code 0 (zero), indicating no, and the resident is rarely/never understood. Section GG revealed Resident #23 was dependent on chair-to-bed-to-chair (wheelchair) transfer. Section O revealed yes responses to both suctioning and tracheostomy care. Review of the physician orders dated 05/21/25 revealed Enhanced Barrier Precautions (EBP) as indicated for Percutaneous Endoscopic Gastrostomy (PEG) tube and tracheostomy, every shift. During an observation on 06/23/25 at 10:00 AM, Resident #23 was awake and sitting in wheelchair. A tracheostomy was observed in front of the neck which was open to air and not attached to an oxygen supply. During a tracheostomy care on 06/24/25 at 4:41 PM, the following were observed:Staff F, Respiratory Therapist, (RT), prepared the supplies on top of resident's meal table without first disinfecting the area. Staff E, RT stated she would help Staff F. Both Staff performed handwashing and donned Personal Protective Equipment (PPE) gown and clean gloves. Resident #23 was inside the crib and lying flat with rails of crib up on both sides.Staff F opened the tracheostomy kit, put a wrapped, unopened sponge dressing over the newly opened sterile tracheostomy kit. When asked why he did that, he stated that is how he always does it. He removed the still wrapped sponge gauze dressing from the top of the tracheostomy kit and put it to the side. Staff F, with clean gloves, approached the resident's bed and started manipulating the neck collar without informing the resident what he was planning to do. The resident remained flat in bed and the crib side rails were up. Staff E, RT stated she would try to hold the tracheostomy tube while Staff F, RT was cleaning and changing the tracheostomy collar and dressing around the resident's neck. Staff E put on sterile gloves but did not maintain sterility. She was touching parts of her wrist with the sterile right-gloved hand, during the donning of the left-hand glove. When Staff E was asked if she maintained one dominant hand sterile, she replied, yes. When asked why she touched the wrist of her left hand with the supposedly sterile right-gloved hand, she went and removed both gloves but did not maintain sterility as well after putting on a new set. When the gloves were both on, she picked up the glove's wrapper using the right hand and touched the crib with her left hand. Staff E went and stayed next to Resident #23's left side and held the tracheostomy tube (crib rails were up, and the resident still lying flat), while Staff F was changing and cleaning the neck collar using dressing wet with saline, dry dressing and a new neck collar found inside the opened tracheostomy kit. Staff F placed a split dressing under the tracheostomy opening.After changing the neck collar and the dressing, Staff F removed his gloves, performed hand hygiene, and opened a tracheostomy suction catheter / cannula kit on the left side of Resident #23's bed. He picked up the right sterile glove from the kit and put it on his right hand, then with the supposedly sterile right gloved hand, he touched his bare left hand with the right gloved hand, while donning the left glove. He did not change his gloves and proceeded. When both gloves were on, the opening flap of the suction cannula kit went back to its original position, so Staff F, using his left hand, opened the flap and grabbed the suction cannula inside using his right hand. When asked if he would change his gloves, he replied, no. He inserted the end tip of the catheter / cannula from the kit into the suction tubing. Staff E turned on the suction switch, then Staff F started to put in the end tip of catheter / cannula inside Resident #23's tracheostomy. Staff F stated, he needed saline. Staff E gave him an unopened saline container. Staff F opened the saline using his right hand while his left hand was holding the suction tubing and the saline container. He placed a drop of saline directly on the tracheostomy opening with the resident lying flat and inserted the cannula to suction one more time using his left hand. When done, both staff were asked if they followed the tracheostomy policy, and they both responded, yes. When Staff F was asked if tracheostomy suctioning is done after changing the neck collar and neck dressing, both did not reply. Record review of respiratory progress notes did not indicate the resident's position during the procedure, and the practice of sterility during suctioning of the tracheostomy tube.In an interview conducted with Staff M, Registered Respiratory Therapist (RRT) and Staff N, Certified Respiratory Therapist (CRT), when asked if they must use sterile technique when performing tracheostomy tube suctioning, replied, We use sterile gloves on our

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of the facility policy titled, Policy and Procedure Braces , provided by the Director of Nursing (DON) revised 10/26/23, documented in the Policy Statement: .braces will be applied according to manufacturer's instructions .Purpose: To prevent pain, discomfort, swelling and stiffness .Braces .Nursing staff will: Always inspect skin carefully before application and after removal. Be gentle and move slowly when applying devices .Caution to not pull strap too tight. Allow your fingers to comfortably fit in between device and skin. Report all skin problems, redness, swelling, pain or changes in fit Document according to facility protocol. Follow applications of braces according to a manufacturer's instructions .Record review revealed Resident #53 was admitted to the facility on [DATE] with diagnoses which included Cerebral Palsy, Traumatic Brain Injury and Orthostatic Hypotension. She had a Brief Interview Mental Status (BIMS) score of 00, indicative of severe impairment; the child is non-verbal and unable to verbalize her needs or distresses. On 01/30/25, the Physician's Order documented for Tracheostomy (Trach) Stoma Care: Clean with normal saline, pat dry and cover with dry dressing every shift.During an observation conducted on 06/23/25 at 10:07 AM, it was observed that Resident # 53 was wearing a Velcro Trach collar/strap brace located just above the child's open Trach stoma site and wrapped around her neck, with no dressing observed at this site; potential choking hazard. Photographic Evidence Obtained. There were no new current specific written physician's orders noted in the record, pertaining to the Velcro Trach collar/strap brace, to indicate that it needed to be checked and that the resident's skin needed to be assessed, nor were there any directives for care and treatment of such. On 06/23/25 at 3:16 PM during a second observation of Resident #53, she was still observed wearing the Velcro Trach collar/strap brace located just above the child's open Trach stoma site and wrapped around her neck, with still no dressing observed at this site. There were no new current written specific physician's orders noted in the record, pertaining to the care and treatment of the Velcro Trach collar/strap brace. On 06/24/25 at 10:21 AM during a third observation of Resident #53, she was observed to have a new/different undated Velcro Trach collar/strap brace located just above the child's open Trach stoma site and wrapped around her neck, with still no dressing observed at this site. There were no new current specific written physician's orders noted in the record, pertaining to the care and treatment of the Velcro Trach collar/strap brace. An interview was conducted on 06/24/25 at 1:22 PM with Staff S, Registered Respiratory Therapist (RRT), in which he checked the record and stated that RRTs do not do any daily routine treatments for Resident #53. He indicated that all tracheostomy care is performed by the nurses. Staff S added that the Tracheostomy care change is done twice per month by the RRTs on every 15th and 27th of the month. On 06/24/25 at 1:39 PM during a fourth observation of Resident #53, she was observed sitting up in her wheelchair in her room and noted as wearing a new/different undated Velcro Trach collar/strap brace located just above the child's open Trach stoma site and wrapped around her neck. There were no new current specific written physician's orders noted in the record, pertaining to the care and treatment of the Velcro Trach collar/strap brace. An interview was conducted on 06/25/25 at 12:50 PM with Staff P, Registered Nurse (RN), who indicated Resident #53 had not exhibited any behaviors while she was providing care to her. Staff P acknowledged there was no current order in Point-Click-Care (PCC) for nursing to provide care and treatment for Resident #53's Velcro Trach collar/strap brace which was located just above the child's open Trach stoma site and wrapped around her neck. Staff P stated she had not changed or provided care to this child's Velcro Trach collar/strap brace. She stated the Respiratory department was primarily responsible for doing this. Staff P stated if nursing were to see something that was an issue or concern, that they would address it as well.On 06/25/25 at 12:59 PM, an interview was conducted with Staff T, Certified Respiratory Therapist (CRT), who indicated Resident #53 had not exhibited any behaviors, while he was providing care to her. Staff T stated that the following physician's order was written for Stoma Care: Clean with normal saline, pat dry and cover with dry dressing every shift and as needed. He acknowledged that currently there was no order in Point-Click-Care (PCC) for RT to provide care and treatment for the child's Velcro Trach collar/strap brace located just above the child's open Trach stoma site and wrapped around her neck. Staff T went on to say that he had not changed nor provided care to this child's Velcro Trach collar strap/brace, because he responded, he was not in the facility, and that sometimes, depending on how the child feels, she may take off the gauze, that would be put in place underneath this Velcro Trach collar/strap brace. Staff T was unable to show written documentation of the child having taken off the gauze, nor was he able to show any documentation of whether or not this child's skin underneath was being

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Review of a policy titled Oral Inhalation Administration revised 2024, documented in part . Nebulizer-Administering Medications through a small volume handheld nebulizer. D. Obtain baseline pulse, respiratory rate and lung sounds. T. Obtain post-treatment pulse, respiratory rate and lung sounds and document findings [on the MAR or in the resident's medical record] Photographic Evidence Obtained. Record review revealed Resident #43 was admitted to the facility on [DATE]. Review of the quarterly comprehensive assessment dated [DATE] documented a Brief Interview Mental Status score of 14 on a 0-15 scale, indicating no cognitive impairment. Record review revealed a physician order for Resident #43 dated 06/24/25 that instructed the staff to administer ipratropium-albuterol [medication to treat breathing difficulty] 3 milliliters by nebulizer three times a day for shortness of breath and wheezing. Review of the MAR for the month of June 2025 indicated that the scheduled times to administer the medication to Resident #43 were 9:00 AM, 2:00 PM, and 9:00 PM. According to the documentation on the MAR, staff were administering the medication. Further review of the MAR did not instruct the staff to document pre or post vital signs and lung sounds when administering the breathing treatment as indicated in the facility's policy. Review of Resident #43 vital sign record or progress notes did not indicate that staff were checking her vital signs or lungs sounds pre or post administration of the nebulizer treatment. 8. Record review revealed Resident #57 was admitted to the facility on [DATE]. Review of the quarterly comprehensive assessment dated [DATE] documented a BIMS score of 15 on a 0-15 scale indicating no cognitive impairment. Review of the physician orders revealed an order dated 01/20/25 that instructed the staff to administer ipratropium-albuterol 3 milliliters by nebulizer every 6 hours as needed for shortness of breath and wheezing. During an interview on 06/25/25 at 1:30 PM, when asked 'how are you doing', Resident #57 stated I'm doing ok. I still have a lot of congestion, as she points to her chest. When asked 'have you been offered a breathing treatment', the resident stated, No, I haven't had one since yesterday. I guess I have to ask for it. Review of the MAR for the month of June 2025 indicated Resident #57 was administered a nebulizer treatment by staff on 06/24/25, 06/25/25, and 06/26/25. According to the documentation on the MAR, staff were administering the medication. Further r[TRUNCATED]

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to provide accurate fluid consistency per the physician orders for thickened liquids for 1 of 3 sampled residents, Resident #408, as evidenced by the resident was provided liquids in the consistency that was not ordered for her. The findings included:1 Record review revealed Resident #408 was admitted to the facility on [DATE]. Review of the initial comprehensive assessment was still in progress and a Brief Interview Mental Status score was not yet documented. There was documented medical diagnoses history of Parkinson's disease (disorder affecting central nervous system) and dementia (memory loss) for Resident #408. Review of the physician orders revealed Resident #408, was on a regular diet that is to be mechanically soft, and the liquids should be of nectar (mildly thick, not thin) thickened consistency. During an observation on 06/23/25 at 12:27 PM, in the resident's room, Resident #408 was sitting up in bed, while being fed by Staff X, Certified Nursing Assistant (CNA). The resident had eaten 80% of her meal. Resident #408 was coughing a lot. When asked how the lunch was, she stated, I'm full. I can't eat anymore. Staff X had a cup of thickened water in her hand that she was attempting to assist the resident with drinking. There was an almost full cup of juice with ice cubes floating on top sitting on the tray, The ice cubes had changed the consistency of the nectar thickened juice. When Staff X was made aware of the ice cubes in the juice, she stated, I didn't give it to her. When asked where the juice came from, she stated, It was on the tray. The Dietician walked into the resident's room and stated she was checking to see how the resident did with eating lunch. At this time, the Dietician was made aware of the ice cubes in the cup of thickened juice. When asked whether Resident #408's juice should have ice cubes in it, the Dietician stated, No, I don't know what happened in the kitchen. Photographic Evidence Obtained.During an interview with the Dietitian, on 06/23/25 at 12:54 PM, she said the kitchen staff was educated on the ice being in Resident #408's thickened juice and the staff said it must have happened by an accident. The Dietitian was made aware of the risk of Resident #408 choking and that she was observed coughing a lot. She stated, I know, it's not an excuse, because it was unsafe for the resident. During an observation on 06/25/25 at 2:08 PM, Resident #408 was noted to have a sippy cup of thickened water with a straw sticking out of it, sitting on the bedside table next to her bed. Photographic Evidence Obtained. (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Record review revealed Resident # 408 was admitted on [DATE] with diagnoses that included Parkinson's Disease without Dyskinesia (involuntary erratic, writhing movements of face, arms, legs or trunk), Recent Thoracentesis (a surgical procedure of removing excess fluids between the lungs and chest wall) related to Pleural Effusion, Acute Respiratory Failure with Hypoxia, and Atrial Fibrillation. Review of admission Minimum Data Set (MDS) assessment under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 13 indicating Resident #408 had intact cognition. Review of the physician orders dated 06/17/25 revealed a regular diet, minced, moist with mildly thick liquids. A nursing care plan review revealed Resident #408 has potential for weight loss and altered nutrition/hydration status. The interventions included providing a regular diet consisting of minced, moist with mildly thick liquids. A review of June 2025 MAR revealed a space for diet was filed with the following information: regular diet 5-minced and moist (mechanical soft ground) texture, 2-mildly thick (nectar thick) consistency. During a medication pass observation on 06/24/25 at 9:33 AM, with Staff L, Licensed Practical Nurse (LPN), who was observed to pour water into a plastic cup. The water was from a pitcher on medication cart 2. She brought this water inside Resident #408's room and provided it to the resident when oral medications were inside the resident's mouth. Resident #408 coughed as soon as she swallowed the water provided by Staff L, LPN. When Staff L, LPN, was asked why she gave the water from the medication cart, and not the thickened fluid which was on top of Resident #408's table and directly in front of the resident, she did not respond. When asked if she read the MAR before providing liquids to this resident, she did not respond. In an interview with the Assistant Director of Nursing on 06/24/25 at 9:47 AM, who when asked how Nurses would know that a resident needed thickened liquids during medication administration, responded, Thickened liquids orders should be written in Medication Administration Record (MAR). He added that every medication cart, must have a thickened liquid container for Staff to provide for residents with thickened liquid orders. When he was asked if he observed any thickened liquid container on Medication Cart 2, which was used by Staff L , LPN, he responded, This cart does not have any thickened liquids. He added that staff must have thickened liquids before starting medication administration to residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety and sanitary conditions, and to prevent foodborne illnesses during two of the two visits to the main kitchen.The findings included:In a tour of the main kitchen on 06/23/25 at 7:58 AM with the Food Service Director, the following issues were noted:a. A round garbage bin was partially covered in the food production area.b. The reach-in freezer contained a yellow-colored frozen food item that was not labeled or dated. c. The reach-in freezer was noted with a box of frozen egg patties that was partially opened to the air and not sealed. d. The reach-in freezer noted five frozen meals of Pot Roast of Beef that did not have an expiration date or the date that they were placed in the reach-in freezer. e. The reach-in Traulsen refrigerator noted 46 fluid ounces of thickened cranberry cocktail, which expired on 06/05/25.f. The walk-in refrigerator was noted with a box of chicken thighs with the bag opened and exposed to the air, not sealed. g. The reach-in Frigidaire was stocked with two personal bottles of water, each 24 ounces. h. The dry storage room noted 46 fluid ounces of thickened cranberry cocktail, which expired on 06/05/25.In an observation conducted on 06/24/25 at 12:40 PM, in the second-floor pantry unit, two packs of vanilla pudding, 4 ounces each, were with an expiration date of 06/12/25. In a second tour of the main kitchen during the lunch tray line on 06/25/25 at 11:15 AM, the following was noted: The Food Service Director was taking the temperature of foods on the tray line using a facility-calibrated thermometer. He was observed putting his bare hands halfway into the food containers to take the temperature of the different foods. In an interview conducted on 06/26/25 at 3:00 PM with the facility's Administrator, he was told of the findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to maintain the infection control standards in the laundry room; failed to maintain a sanitary environment during tube feeding for 1 of one sampled resident, Resident #95; failed to maintain the infection control standards for Enhanced Barrier Precautions (EBP), for 2 of 64 sampled residents, Resident #19 and Resident #88; and failed to follow the Center for Disease Control and Prevention (CDC), EBP guidelines for 4 of 64 sampled residents, that included 56 adults and 8 pediatrics, Resident #31, Resident #6, Resident #23, and Resident #25. The findings included:Review of the Center for Disease Control and Prevention (CDC), Enhanced Barrier Precautions guidelines, revealed the following: Everyone must clean their hands, including when both entering and leaving the room: Providers and Staff must also wear gloves and a gown for the following; high-contact care resident care activities, dressing, bathing-showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting: Device care or use; central line, urinary catheter, feeding tube, tracheostomy: Wound care with any skin opening requiring a dressing. Website: https://www.cdc.gov/long-term-care facilities/media/pdfs/Review of the facility's Enhanced Barrier Precautions (EBP) policy with an implementation date of 04/01/24, revealed the following: EBP is an infection control intervention designed to reduce transmission of multi-drug-resistant organism; All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions.Review of the facility's policy titled, Care and Treatment of Feeding Tubes, with a revision date of 04/01/24 revealed the following: to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible; to use infection control practices and related techniques to minimize the risk of contamination (7.e).1. Record review revealed Resident #31 was admitted on [DATE] with diagnoses that included Cerebral Palsy, Gastro-Esophageal reflux Disease without Esophagitis, Hypoxic Ischemic Encephalopathy, Tracheostomy status, and Persistent Vegetative State. Review of the most recent Minimum Data Set (MDS) assessment, dated 06/02/25, under Section C of the Brief Interview of Mental Status (BIMS) revealed a score of 0, or a no, indicating Resident #31 is rarely/never understood indicating severe cognitive impairment. Review of the physician orders dated 05/25/25 revealed EBP is indicated for percutaneous endoscopic gastrostomy (PEG) tube and tracheostomy every shift; wound consult for the left knee; apply [NAME] bag (a closed enteral decompression system to allow evacuation of excess gas and drainage collection of enteral feeding formula) to g tube continuously, okay to clamp for 1 hour after medications were given. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing care plan dated 02/13/25 revealed Resident #31 requires EBP related to tube feeding, tracheostomy and ventilator dependency. The nursing care plan goal was for this resident to be free from multi-drug-resistant organism (MDRO) through review date by the following interventions: ensure access to alcohol-based hand rub; perform hand hygiene before and after caring for this resident, provide education to the resident/ family, responsible party and visitors.During an observation on 06/23/25 at 9:13 AM, Resident #31's Ambu bag and emergency respiratory tube and supplies were on the bottom part of his bed. The system was not contained in the bag and was not dated.During the continuing observation conducted on 06/23/25 9:15 AM, Staff F, Respiratory Therapist (RT), who has been working in the facility for 5 years, did not perform hand hygiene when he entered the residents' room. The room had an EBP sign on the door. He touched the resident's Ambu bag and respiratory supplies on the foot part of the bed and dug inside a black bag, showing the surveyor of another Ambu bag was inside a plastic bag on 06/23/25 09:16 AM. Staff F left the room without performing hand hygiene and went into the next room. He did not perform hand hygiene before entering another resident's room and after leaving another resident's room. 2. Record review revealed Resident #6 was admitted on [DATE] with diagnoses that included Spastic Quadriplegic Cerebral Palsy, Vegetative State, Anoxic Brain Damage, Tracheostomy and Gastrostomy status.Review of the most recent MDS dated [DATE] revealed the BIMS score was disabled by questions C100, indicating resident is never/rarely understood, indicating severe cognitive impairment. Review of physician orders revealed the following: on 01/13/22, tracheostomy care twice daily & as needed; on 04/28/25, enteral feed; and on 05/21/25, EBP for PEG tube and tracheostomy every shift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing care plan dated 02/13/25 revealed a goal for Resident #6 to be EBP related to tube feeding, tracheostomy and ventilator dependency. The interventions included make gown, gloves and face protection available and use for high contact activities; ensure access to alcohol-based hand rub; and perform hand hygiene before and after caring for the resident. During observation on 06/23/25 09:23 AM, Resident #6's Ambu bag and emergency respiratory tube were on the on the foot part of his bed. The respiratory tubing and system were undated and not contained in a bag. The observation revealed the oxygen tubing had a date of 06/15 (8 days old).Staff F, RT, when he saw the Ambu bag and respiratory supplies on the foot part of the bed, gathered and put them in a bag. He did not perform hand hygiene before touching the respiratory supplies and after putting them in the bag. He did not perform hand hygiene before leaving the resident's room. 3. A record review revealed Resident #23 was admitted on [DATE] with diagnoses that included Arnold Chiari Syndrome (a structural defect in the brain where brain tissue extends into the spinal column) with Spina Bifida (a birth defect characterized by failure of the spinal cord to develop properly), and Hydrocephalus (an abnormal buildup of cerebrospinal fluid within the brain's ventricles), respiratory Failure with Hypoxia, Anoxic Brain Damage, and Gastrostomy status. A review of recent MDS dated [DATE] revealed BIMS was disabled by C0100 indicating a score of 0 or no, resident is rarely/never understood. Section O revealed yes responses to suctioning and tracheotomy care. An additional review of physician orders revealed the following: suction oropharyngeal and nasopharyngeal airway as needed, every 4 hours; EBP as indicated for PEG tube and tracheostomy, every shift; tracheostomy care twice daily and as needed, and every shift; document tolerance of procedure in progress notes. A further review of Resident #23's nursing care plan dated 01/17/25 revealed goals to prevent the risk of decannulation, pneumonia, acute respiratory infections, aspiration, tracheitis, atelectasis and respiratory distress. The interventions were the following: assure tracheostomy collar is secured and maintain an open airway. During an observation conducted on 06/24/25 at 4:37 PM, Staff E, RT entered the resident's room without performing hand hygiene. She immediately put on a yellow PPE (personal protective equipment) gown.Staff F, RT , did not perform hand hygiene before entering the residents' room and did not disinfect the area where respiratory supplies were opened before tracheostomy care. During a tracheostomy care on 06/24/25 at 4:41 PM, the following were observed:Staff F, Respiratory Therapist, (RT) prepared the supplies on top of resident's meal table without first disinfecting the area. Staff E, RT stated she would help Staff F. Both staff performed handwashing and donned Personal Protective Equipment (PPE) gown and clean gloves. Resident #23 was observed inside the crib and lying flat with rails of crib up on both sides.Staff F, RT opened the tracheostomy kit, but put a wrapped, unopened sponge dressing over the newly opened sterile tracheostomy kit. Staff F contaminated the sterile supplies inside the kit by placing an unopened sponge dressing on top of it. When asked why he did that, he stated that is how he always does it. He removed the still wrapped sponge gauze dressing over the top of the tracheostomy kit and put it to the side. Staff F, while with clean gloves on, approached the resident's bed and started manipulating the neck collar of the trach without informing the resident what he was planning to do. The resident remained flat in bed and the crib side rails were up. Staff E stated she would try to hold the tracheostomy tube while Staff F was cleaning and changing the tracheostomy collar and dressing around the resident's neck. Staff E put on sterile gloves but did not maintain sterility, as evidenced by touching parts of her wrist with the sterile right-gloved hand, during the donning of the left-hand glove. When she was asked if she maintained one dominant hand sterile, she replied, yes. When asked why she touched the wrist of her left hand with the supposedly sterile right-gloved hand, she removed both gloves but did not maintain sterility as well after putting on a new set, as she picked up the gloves' wrapper using the right hand and touched the crib with her left hand. Staff E stayed next to Resident #23's left side and held the tracheostomy tube, while Staff F was changing and cleaning the neck collar using dressing wet with saline, dry dressing and a new neck collar found inside the opened tracheostomy kit. Staff F placed a split dressing under the tracheostomy opening.After changing the neck collar and the dressing, Staff F removed the gloves, performed hand hygiene, and opened a tracheostomy suction catheter/cannula kit on the left side of Resident #23's bed. He picked up the right sterile glove from the kit and put it on his right hand, then touched his bare left hand with the right gloved hand, while donning the left glove. He did not change his gloves and proceeded. When both gloves were on, the opening flap of the suction cannula kit went back to its original position, so Staff F using his left hand, opened the flap and

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	105175	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plantation Nursing & Rehabilitation Center	4250 NW 5th St Plantation, FL 33317

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During an interview conducted on 06/24/25 at 4:11 PM with Staff W, Registered Nurse (RN) she stated that in between feedings, when the TF is not in use, that she will either use the original clear plastic cover that is packaged with the TF tubing kit, or she will use a replacement white top cover called the Enteral Distal End Enfit Transition Connector with cap to cover the TF tip. Staff W went on to say that these caps are supposed to be kept on top of the IV pole, next to the child's TF bag and then put in place in order to prevent infection. Staff W ended by acknowledging that she had not covered the TF tip end, which had been uncovered and exposed, prior to insertion into the child's abdominal J-tube site. Record review of the Resident # 53's Care plan initiated 02/19/25 indicated Focus: Child is at risk for alteration in nutritional status and aspiration. Related to neurological impairments. Total nutritional/hydration support via tube feeding. Interventions: Provide enteral nutrition support as ordered and readjust as needed .Goal: Provide adequate nutritional/hydration support appropriate for weight/growth without signs and symptoms of aspiration on daily on-going basis. Maintain Body Mass Index (BMI) for age =/> 5th% tile with no signs or symptoms of dehydration and intact skin .The Administrator and the DON both further recognized and acknowledged on 06/24/25 at 4:20 PM and on 06/25/25 at 2:40 PM that (J-tube) tip tubing should remain covered and capped, when not actively in use and infusing. And, proper infection control techniques should always be practiced during a resident's tube feeding (TF).7. Review of the facility policy titled, Suprapubic Catheter Care, provided by the DON, reviewed 01/2025, documented in the Policy Statement: Purpose: The purpose of this procedure is to prevent skin irritation around the stoma site and to prevent infection of the resident's urinary tract. Preparation: Review the resident's care plan to assess for any special needs of the resident. Assemble the equipment and supplies as needed .Equipment and Supplies: .Personal protective equipment (e.g. gowns, gloves, mask, etc. as needed) Review of the facility policy for EHB, provided by (Director of Nursing) DON implemented 04/01/24, documented in the Policy Statement: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions EBP refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: .2. Initiation of Enhanced Barrier Precautions: .b. An order for enhanced barrier precautions will be obtained for residents with any of the following: . indwelling medical devices (e.g Urinary Catheters even if a resident is not known to be infected or colonized with an Multi-Resistant Drug Organism (MDRO) 3. Implementation of Enhanced Barrier Precautions: a. Make gowns (may use reusable gowns) and gloves available immediately near or outside of the resident's room .b. Personal Protective Equipment (PPE) for enhanced barrier precautions is only necessary when performing high-contact care activities and may not be donned prior to entering the resident's room .4. High-contact resident care activities include: .g. Device care or use: .Urinary Catheters/Supra-pubic) .10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until discontinuation of the indwelling medical device that placed them at higher risk. On 06/24/25 at 2:43 PM, a Suprapubic Catheter Care observation was conducted of Resident #19, who was resting in bed with the television on. The physician order dated 06/24/25 was for Indwelling Suprapubic Catheter Size: 18 Fr 20 CC: Obstructive UROPATHY. Staff X, Certified Nursing Assistant (CNA), was present and was assisted by Staff Y, Registered Nurse (RN)/Unit Manager (UM) of the 2nd floor Geriatric Unit, in removing Resident #19's Suprapubic dressing and providing catheter care to the resident. On 06/24/25 at 3:10 PM Staff Y, gathered some supplies, washed her hands before and after 35-40 seconds, she only donned a clean pair of gloves. Staff Y then proceeded to clean the surrounding skin area with normal saline and then she applied a border dressing. Lastly, Staff Y dated and applied the split border dressing to Resident #19's Suprapubic catheter site. Staff Y was not observed to first don a clean yellow gown, prior to, or at any time during the Suprapubic catheter dressing procedure for Resident #19, who was on Enhanced Barrier Precautions (EBP), as per initial order date of 11/11/24 Record review of the Resident #19's care plan initiated 03/04/20 indicated

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