STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106110	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Childrens Comprehensive Care Center Inc	200 SE 19th Avenue Pompano Beach, FL 33060

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observation and interview, the facility failed to assist a resident with feeding in a manner to promote dignity for 1 of 3 residents that eat by mouth, Resident #17. The findings included: Resident #17 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, an Annual Minimum Data Set (MDS), dated [DATE], Resident #17 was not assessed for cognition due to 'Resident is rarely/never understood'. The MDS documented that Resident #17 was dependent upon staff for all Activities of Daily Living (ADLs), including eating. Resident #17's care plan for nutrition, initiated on 07/31/23, documented, Feeding tube present due to dysphagia with H20 flush only for hydration, patency of tube and medication administration. Additional risk factors include: chewing/swallowing difficulty, mechanically altered diet, decreased ability to feed self, abnormal labs. The goal of the care plan was documented as, Resident will have no further weight gain through next review date. Interventions to the care plan included: o Assist with meals PRN (as needed) During an observation of lunch served to Resident #17, on 11/18/24 at 1:03 PM, Resident #17 was observed in an outside area with Staff L, Teacher's Assistant. During the observation, it was noted that Staff L was standing over and to Resident #17's right while assisting the resident with the lunch meal. The concern was brought to the attention of the Activities Director who acknowledged the concern and corrected Staff L.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on observations, interviews and record review, the facility failed to: -develop a care plan for activities of daily living (ADLs) for 2 of 4 residents reviewed for ADLs (Resident # 7, and #19) ; -develop a care plan related to skin impairment for 1 of 2 residents reviewed for pressure injury (Resident #19); and -follow the care plan for residents with seizure precautions and pad placement on the bed rails for 1 of 3 reviewed for bed rails (Resident #130). The findings included: 1) Review of Resident #7's clinical record documented an admission on 09/26/16 and most recent readmission on 11/13/24. The resident diagnoses included Cerebral Palsy, Restlessness and Agitation, Seizures, Feeding Difficulties, Hypoxic Ischemic Encephalopathy, Tracheostomy Status, Acute Respiratory Failure with Hypoxia, Candidiasis of Skin and Nail, and Sepsis due to Methicillin Susceptible Staphylococcus Aureus. Review of Resident #7 Minimum Data Set (MDS) assessments documented a discharge-return anticipated assessment dated [DATE]. The assessment documented that the resident was dependent on the staff for all activities of daily living (ADLs). Review of Resident #7's active care plan record revealed that a care plan for the resident ADLs was not developed. On 11/22/24 at 12:53 PM, a joint interview and a side by side review of Resident #7's active care plans was conducted with Staff A, Resident Care Manager and another surveyor. Staff A stated that the residents had a separate plan of care for ADLs for the Certified Nursing Assistant (CNAs). Staff A was asked to show that care plan and added the review of the plan of care and the weekly meeting was for nursing, Therapists, Social Worker and the Nutritionist. Staff A stated that the plan of care (care plans) were not targeted for CNAs. The review of random residents revealed some had an ADL care plan developed and some did not. Staff A confirmed that an ADL care plan was not developed for Resident #7 and that there was not consistency in the development of the resident's care plans. 2) Review of Resident #19's clinical record documented an admission on 01/23/23 with the most recent readmission on 11/16/24. The resident diagnoses included Tracheostomy, Gastrostomy, Anoxic Brain Damage and Contracture-Unspecified Joint. Review of Resident #19's MDS discharge return-anticipated assessment dated [DATE]. The assessment documented that the resident was dependent on the staff for all activities of daily living (ADLs). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's active care plans on file revealed that a care plan for the resident ADLs was not developed. On 11/22/24 at 1:13 PM, a joint interview and a side by side review of Resident #19's active care plans was conducted with Staff A, Resident Care Manager and another surveyor. Staff A stated that the residents had a separate plan of care for ADLs for the Certified Nursing Assistant (CNAs). Staff A was asked to show that care plan and added the review of the plan of care and the weekly meeting was for nursing, Therapists, Social Worker and the Nutritionist. Staff A stated that the plan of care (care plans) were not targeted for CNAs. The review of random residents revealed some had an ADL care plan developed and some did not. Staff A confirmed that an ADL care plan was not developed for Resident #19 and that there was not consistency in the development of the resident's care plans. 3) Review of Resident #19's clinical record documented an admission on 01/23/23 with most recent readmission on 11/16/24. The resident diagnoses included Tracheostomy, Gastrostomy, Anoxic Brain Damage and Contracture-Unspecified Joint. Review of Resident #19's clinical record documented an active physician orders dated 10/11/24 Wound Care Left Dorsal foot: Cleanse with NS (normal saline), dry, apply skin prep then apply Thin Duoderm three times a week one time a day every Mon, Wed, Fri for Unstageable DTI (Deep Tissue Injury) of left dorsal foot for 30 Days-Start Date10/14/2024. The order entry on file did not have a stop date. Review of Resident #19's active and resolved care plans on file revealed that a care plan for the resident Skin impairment (Deep Tissue Injury) was not developed. On 11/20/24 at 10:14 AM, observation revealed Resident #19 lying on his back with his feet propped up. On 11/20/24 10:58 AM, a side by side observation of Resident #19's left dorsal foot was conducted with Staff B, Registered Nurse (RN). Staff B entered the resident's room and stated the resident had a dressing on his left dorsal foot. Staff B lifted the dressing and stated Resident #19 had a DTI on the left dorsal foot. Staff B was asked what type of dressing the resident had in place and stated he had a 4 x 4 Mepilex dressing dated 11/19/24- 5:00 AM. On 11/20/24 at 4:12 PM, an interview was conducted with Staff A, Resident Care Manager (RCM) who stated Resident #19's left dorsal foot wound care was only for 30 days and was completed on 11/14/24. On 11/22/24 at 1:13 PM, a joint interview and a side by side review of Resident #19's active care plans was conducted with Staff A, Resident Care Manager and another surveyor. Staff A was asked for the resident's pressure injury- skin impairment care plan. Staff A stated she did not see one and stated the resident should had a skin impairment care plan developed and it was not done. 38893 4) The facility's policy, Seizure Precautions, most recently revised February 2024, documented: Standard Precautions: Obtain pads for side rails and airway. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Place pads on side rails. Resident #130 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly MDS, dated [DATE], Resident #130 was not assessed for cognition due to 'Resident is rarely/never understood'. The assessment documented that Resident #130 was dependent upon staff for all ADLs, including bed mobility and transfer. Resident #130's diagnoses included: Aphasia, Seizure disorder, and Contracture. Resident #130's Care plan for seizures, initiated on 01/12/20, documented, Resident has Seizure Disorder r/t Head injury. Interventions in the care plan included: o SEIZURE PRECAUTIONS: Do not leave resident alone during a seizure. Protect from injury. If resident is out of bed, help to the floor to prevent injury. Remove or loosen tight clothing. Don't attempt to restrain resident during a seizure as this could make the convulsions more severe. Protect from onlookers, draw curtain etc. Resident #130's care plan for bed rails, initiated 05/24/22, documented, Use of full rails up for prevention of injury to self -characterized by high risk for falls related to disease process and contractures. The Goal of the care plan was documented as, Resident will have no falls. Interventions of the care plan included: Bed rails used daily with no bed/chair alarms indicated. On 11/18/24 at 11:00 AM, Resident #130 was observed in bed with bilateral side rails the length of the mattress in raised position. Resident #130 did not respond to being greeted. The rails appeared to be hard metal with standard pillows propped up against part of the rail at approximately the middle of the bed. On 11/19/24 at 9:26 AM, Resident #130 was observed in bed with bilateral rails the length of the mattress in raised position. The rails were noted to be metal with no padding. During an interview, on 11/22/24 at 10:41 AM with Staff M, LPN, when asked about seizure precautions for Resident #130, Staff M replied, when he is having a seizure we lower the bed, put a pillow under the head and remove everything from the bed and give the medication. When asked about padding for the rails, Staff M replied, they should have padding that covers the entire rail. During an interview, on 11/22/24 at 12:15 PM, with Staff A, Resident Case Manager, when asked about seizure precautions for Resident #130, Staff A replied, we need to take care of the patient first, the bed should be in the lowest position. When asked about the pads, Staff A replied, for the adults I have to go to the Director of Medical Operations to find out about the pads. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 11/22/24 at 12:30 PM, with the Director of Medical Operations and the Administrator, when asked about seizure precautions, the Director of Medical Operations replied, we put bumpers around the bed or bed rails or a note for staff to be aware the resident has seizures. If you know that the patient has seizures, then the pads should be on the bed at all times. Usually, they (referring to the pads) are kept in the laundry. If they have a history of seizures or have a breakthrough seizure, we have vinyl and fabric. The Director of Medical Operations further stated that the facility uses bumpers pads from the therapy department for padding. When asked to see the pads that should be on the residents' beds, the Director of Medical Operations and this Surveyor went to the Laundry and there were no pads in the Laundry. Staff then led this Surveyor to a Clean Utility Room and stated that the pads should be in the cabinet. Once in the utility room, staff went through the cabinets and was unable to located any pads. Staff reported that the pads had been relocated to an attic space over the Medical Records office. Once in the Medical Records office, the Director of Medical Operations was unable to open the hatch to the attic and unable to access the pads.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on observations, interviews and record review, the facility failed to provide fingernail grooming to 4 of 4 residents reviewed for Activities of Daily Living (ADL) (Resident #7, #8, #12 and #19). The findings included: Review of the facility's policy provided by the Director of Nursing (DON) titled ADLs/Hygiene reviewed on 01/2024 documented .every resident will receive a bath daily .according to their needs .personal hygiene: i.e. face and hands washing .nails cutting .will be done as needed . Review of the facility's Certified Nursing Assistant (CNA) job description revised on 08/22/19 provided by the Director of Nursing (DON) documented under essential functions .adheres to schedule and performs bathing . and hygiene of residents .ensure residents are ready for school, that they are neat and clean . Review of the facility's Registered Nurse job description revised on 09/21/20 provided by the Director of Nursing (DON) documented under essential functions .provides physical hygiene measures, assures residents are appropriately .well groomed . Review of the facility's Licensed Practical Nurse job description revised on 10/27/20 provided by the Director of Nursing (DON) documented under essential functions .see that the children are clean at all times, bath and grooming . 1) Review of Resident #7's clinical record documented an admission on 09/26/16 with the most recent readmission on 11/13/24. The resident diagnoses included Cerebral Palsy, Restlessness and Agitation, Seizures, Feeding Difficulties, Hypoxic Ischemic Encephalopathy, Tracheostomy Status, Acute Respiratory Failure with Hypoxia, Candidiasis of Skin and Nail, and Sepsis due to Methicillin Susceptible Staphylococcus Aureus. Review of Resident #7 Minimum Data Set (MDS) documented a discharge-return anticipated assessment dated [DATE]. The assessment documented the resident was dependent on the staff for all activities of daily living (ADLs). On 11/18/24 at 11:13 AM, observation revealed Resident # 7 sitting in a wheelchair in the classroom. The resident did not respond to verbal stimuli, was non-verbal. Further observation revealed the resident had long, jagged fingernails with black matter underneath the nails. On 11/19/24 at 11:43 AM, observation revealed Resident # 7 sitting in a wheelchair in the classroom. The resident was non-verbal. Further observation revealed the resident had long, jagged fingernails with black matter underneath the nails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 3:02 PM, a side by side observation of Resident #7 fingernails was conducted with Staff E, RN and Staff C, CNA. Staff C was asked who was responsible to trim the resident's fingernails and stated the Resident Care Manager. She stated the CNAs did not do that. Staff E, RN was asked who was responsible to do the resident's fingernails and she stated she really didn't know who was responsible to do it. Staff C stated Resident #7 needed his fingernail trimmed. 2) Review of Resident #12's clinical record documented an admission on 09/13/19 and a readmission on 03/12/24. The resident diagnoses included Traumatic Brain Injury, Gastrostomy Status, Encephalopathy, and Contracture of Muscle-Unspecified Upper Arm. Review of Resident #12's MDS quarterly assessment dated [DATE] documented the resident was totally dependent on staff for ADLs. Review of Resident #12's active care plans record did not include a care plan related to refusal for care or fingernail care. On 11/18/24 at 11:01 AM, observation revealed Resident #12 in his room sitting in a wheelchair listening to his musical I-Pad game. The resident was called by his name and did not answer. Observation revealed the resident's left hand fingernails were long with black matter underneath the nails, his right hand had a closed fist. The resident was asked if he want the long nails trimmed and moved his head side to side (negative). The resident was asked to open his right fist and moved his head side to side, could not open it. On 11/19/24 at 3:12 PM, a side by side observation of Resident #12's fingernails was conducted with Staff E, RN and Staff O, CNA. Staff E acknowledged the resident's left fingernails were long with black matter underneath the nails. Staff O stated that the resident refuses to get them cut and the previous Resident Care Manager was aware. Staff E stated she was not aware of Resident #12 refusing to have his fingernails groomed and proceeded to clean underneath the resident's fingernails. Staff O was asked about the resident's right hand and opened his right hand that revealed long fingernails and redness on the palm of his hand. Staff O was asked if the nails dig into the skin and she stated a little. On 11/19/24 at 3:18 PM, during an interview, Staff E, RN stated the Activities Director was in charge of doing the resident's fingernails. On 11/19/24 at 3:45 PM, a side by side observation with the Activities Director and Staff A, Resident Care Manager (RCM) was conducted. The Activities Director stated she cut Resident #12's fingernails last time on 10/22/24 and added that the resident never had refused her to have the fingernails cut. Staff A stated she was not aware of the resident refusing nail care. 3) Review of Resident #19's clinical record documented an admission on 01/23/23 with the most recent readmission on 11/16/24. The resident diagnoses included Tracheostomy, Gastrostomy, Anoxic Brain Damage and Contracture-Unspecified Joint. Review of Resident #19's MDS discharge return-anticipated assessment dated [DATE]. The assessment documented that the resident was dependent on the staff for all activities of daily living (ADLs). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 10:14 AM, observation revealed Resident #19's fingernails were long and jagged. The resident was non-verbal, did not respond to verbal stimuli. On 11/19/24 at 11:18 AM, a telephone call was made to the resident's mother who stated the facility staff takes care of him. An inquiry was made regarding the resident's long fingernails and the resident's mother stated she prefers to have them cut his nails because he may scratch himself. On 11/19/24 at 3:30 PM, during an interview, Staff B, RN was asked who was responsible for the resident's fingernail care and she stated that the nurses were responsible for cutting the resident's fingernails. Staff B was asked if the CNA could do it and she stated No. On 11/19/24 at 3:31 PM, a side by side observation of Resident #19's fingernails was conducted with the Activities Director, Staff A, RCM and Staff B, RN. The Activities Director stated that she normally does the resident's fingernails on Friday and added that some resident's nails grow very fast and have to be done weekly. The Activities Director acknowledged Resident #19's fingernails needed to be cut. Staff A, RCM stated that the CNAs could be doing the resident's fingernails and added it was a matter of dividing the task. Staff A stated the CNA can clean underneath the nails during bathing. On 11/19/24 at 3:43 PM, during an interview, the Director of Nursing and the Director of Medical Operations were apprised of the residents with long fingernails. 38349 4) Resident #8, is medically fragile with a Ventilator and Tracheostomy in place and totally dependent on staff for care, nutrition and hydration. She was originally admitted to the facility on [DATE] with diagnoses which included Primary Pulmonary Hypertension, Atrioventricular Septal Defect, Chronic Respiratory Failure, Diabetes Mellitus Type 1 and Gastrostomy status. She had a Brief Interview Mental Status (BIM) score of 00, indicating severe impairment. During an observational tour conducted of the Nursery on 11/18/24 at 12:45 PM, it was revealed that Resident #8, was asleep in her crib and her fingernails were long and un-trimmed. During a second observational tour of the Nursery conducted on 11/18/24 at 4 PM, Resident #8, was resting in her crib and her fingernails were still observed as long and un-trimmed. On 11/19/24 at 3:02 PM, a side-by-side observation and interview was conducted with Staff E, a Registered Nurse (RN) and with Staff C, a Certified Nursing Assistant (CNA) regarding Resident #8's long, un-trimmed fingernails. Staff C, acknowledged that Resident #8's fingernails should be kept trimmed and she stated that either the nurses, or the former Resident Care Manager will cut the resident's fingernails; the CNAs don't do this. During an interview conducted on 11/22/24 at 8:45 AM, with the Activities Director, she also acknowledged that the resident's fingernails should be kept trimmed, but she stated that she did not cut Resident #8's fingernails. The Activities Director added that someone else must have done so. She ended by saying that CNAs and nurses can do the fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #8's Monthly CNA ADL (Activities of Daily Living) Task Flowsheet Record dated 11/18/24 revealed for the following two (2) times, that it was documented at 6:44 AM and again at 5:17 PM, that ADL Personal Hygiene care had been provided for Resident #8. However, Resident #8's fingernails remained long and untrimmed on both hands for the full day of 11/18/24. Record review of the Resident #8's Care plan initiated 07/14/17 indicated Focus: At Risk for .Other Skin Condition Interventions: . Keep residents fingernails cut and filed .Goal: Resident will maintain intact skin integrity through the next ninety (90) days. The DON further recognized and acknowledged on 11/19/24 at 2:30 PM that the Resident #8's fingernails should be kept trimmed and neat; this was not done.

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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** 36057 Based on observations, interviews and record review the facility: - failed to notify and obtain a physician order prior to provide pressure injury care for 1 of 2 reviewed for pressure injury (Resident #19) and - failed to administer medications within the medications time frames identified during medication administration observation task (Resident #18, #24, #28 and #29). The findings included: Review of the facility's policy provided by the Director of Nursing (DON) titled Physician' Medication Orders dated on 03/20/24 documented .no drugs or biologicals shall be administered except upon the order of a person duly licensed .all drug and biological orders shall be written . Review of the facility's policy provided by the Director of Nursing (DON) titled Medication Administration and Documentation revised on 03/20/24 documented .medications must be administered in a timely manner and in accordance with the Attending Physician's written/verbal orders .medications .must be administered within one (1)hour of their prescribed time .the individual administering the medication must initial the resident's MAR (Medication Administration Record) .after administering the next resident's medication .establish facility infection control procedures (e.g. handwashing, antiseptic technique, gloves .etc.) must be followed during the administration of medications . 1) Review of Resident #19's clinical record documented an admission on 01/23/23 and readmission on 11/16/24. The resident diagnoses included Tracheostomy Status, Gastrostomy Status, Anoxic Brain Damage and Contracture-Unspecified Joint. Review of Resident #19's MDS discharge return-anticipated assessment dated [DATE]. The assessment documented that the resident was dependent on the staff for all activities of daily living (ADLs). Review of Resident #19's active and resolved care plans on file revealed that a care plan for the resident Skin impairment (Deep Tissue Injury) was not developed. Review of Resident #19's documented an active physician orders dated 10/11/24 Wound Care Left Dorsal foot: Cleanse with NS (normal saline), dry, apply skin prep then apply Thin Duoderm three times a week one time a day every Mon, Wed, Fri for Unstageable DTI (Deep Tissue Injury) of left dorsal foot for 30 Days-Start Date 10/14/2024. The order entry on file did not have a stop date. On 11/20/24 at 10:14 AM, observation revealed Resident #19 lying on his back with his feet propped on pillow with a dressing on his left foot. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 10:58 AM, an interview with Staff B, Registered Nurse (RN) who was asked when she will be doing Resident #19's foot dressing and stated she did not have a physician order for it. Staff B reviewed the resident's physician orders and stated she did not see one. Observation revealed Staff B donned a gown and gloves, entered the resident's room and stated the resident had a Mepilex dressing on his left dorsal foot. Staff B lifted the dressing and stated Resident #19 had a DTI on the left dorsal foot, and added he had a 4 x 4 Mepilex dressing dated 11/19/24- 5:00 AM. The review revealed the resident had a dressing change without a physician order on 11/19/24. Staff B stated she will do wound care for Resident #19's left dorsal DTI. On 11/20/24 at 11:56 AM, observation of wound care for Resident #19's left dorsal foot DTI performed by Staff B, RN was conducted. Staff B stated the physician order dated 10/11/24 was for skin prep and cover with thin Duoderm. Staff B cleaned the skin injury (DTI) with the skin prep, applied an Extra Thin Duoderm. Staff B provided Resident #19's pressure injury care without physician order. On 11/20/24 at 4:12 PM, an interview was conducted with Staff A, Resident Care Manager (RCM) who stated Resident #19's left dorsal foot wound care was only for 30 days and was completed on 11/14/24. Staff A stated that today (11/20/24) she spoke with the Wound Care Physician who stop the left dorsal foot DTI care order and added he did not want to continue with Duoderm dressing. Staff A stated there was not a physician order for Resident #19's dressing to the left foot. Staff A was apprised that the resident had a Mepilex dressing on his left dorsal foot dated 11/19/24- 5:00 AM. Staff A stated whoever put the dressing on it, put it without a doctor's orders. Staff A was asked if there was a progress note related to the dressing placed on 11/19/24 at 5:00 AM and stated there was no nursing notes related to the left foot dressing. Staff A was apprised of Staff B performing wound care on today (11/20/24) without physician orders. 2) On 11/21/24 at 10:16 AM, during observation of Staff G, Registered Nurse (RN) documentation of medications administration for Resident #27, it was noted that the medication record screen turned from green to red color. An inquiry was made and Staff G stated the screen was red because she was late administering the medications. Staff G was asked why she was late and stated because they used to schedule two nurses for the nursery and now there is only one nurse for 10 residents, there were 12 residents in the nursery. Staff G stated the other two residents were assigned to other nurses. Staff G was asked how many more residents were due to administer their 8:00 AM-and 9:00 AM medications and stated three (3) more residents (Resident #18, #24, and #29). A side by side observation of Staff G's assigned residents medications screen was conducted. The observation revealed Resident #18, #24, and #29 medication screen showed red color, and Staff G stated it was red because she was late to give the resident's medications. 2a) Review of Resident #18's clinical record documented admission on 05/06/22 and a readmission on 07/01/24. Review of Resident #18's 11/21/24 Medication Administration Record (MAR) documented the following: -Keppra oral solution 100 milligrams (mg) per ml (millimeters) via G-tube (gastrostomy tube) two times a day at 9:00 AM and 9:00 PM. Review of Resident #18's medication administration audit report documented that Keppra scheduled for 9:00 AM was documented as administered at 11:00 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lactulose oral solution 10 mg/15 ml via G-tube (gastrostomy tube) two times a day at 8:00 AM and 8:00 PM. Review of Resident #18's medication administration audit report documented that Lactulose scheduled for 8:00 AM was documented as administered at 11:00 AM. -Monitor vital signs every 8 hours at 8:00 AM, 4:00 PM and 12 Midnight. Review of Resident #18's medication administration audit report documented that the resident's vital signs scheduled for 8:00 AM was documented as completed at 11:14 AM. 2b) Review of Resident #24's clinical record documented an admission on 09/25/24 and a readmission on 11/11/24. Review of Resident #24's 11/21/24 Medication Administration Record (MAR) documented the following: -Sodium Chloride Oral solution 4 Meq per ml via J-tube (feeding tube) for Hyponatremia (low sodium) two times a day at 8:00 AM and 8:00 PM. Review of Resident #24's medication administration audit report documented that Sodium Chloride scheduled for 8:00 AM was documented as administered at 10:39 AM. -Amlodipine oral suspension 3.5 mg via J-tube for Hypertension two times a day at 8:00 AM and 8:00 PM. Review of Resident #24's medication administration audit report documented that Amlodipine scheduled for 8:00 AM was documented as administered at 10:39 AM. 2c) Review of Resident #29's clinical record documented an admission on 08/13/24 with no readmissions. Review of Resident #29's 11/21/24 Medication Administration Record (MAR) documented the following: -Docusate Sodium Oral Liquid 50 mg via G-tube (feeding tube) for Constipation two times a day at 8:00 AM and 8:00 PM. Review of Resident #29's medication administration audit report documented that Docusate Sodium scheduled for 8:00 AM was documented as administered at 11:00 AM. -Famotidine oral suspension 40 mg via G-tube for GERD (Gastroesophageal Reflux Disease) two times a day at 8:00 AM and 8:00 PM. Review of Resident #29's medication administration audit report documented that Amlodipine scheduled for 8:00 AM was documented as administered at 11:00 AM. -Glycopyrrolate Oral Solution 1.75 ml via G-Tube two times a day at 9:00 AM and 9:00 PM. Review of Resident #29's medication administration audit report documented that Glycopyrrolate Oral Solution scheduled for 9:00 AM was documented as administered at 11:00 AM. -Levetiracetam oral solution give 350 mg via G-tube for Seizures two times a day at 8:00 AM and 8:00 PM. Review of Resident #29's medication administration audit report documented that Levetiracetam scheduled for 8:00 AM was documented as administered at 11:00 AM. -Monitor vital signs every 8 hours at 8:00 AM, 4:00 PM and 12 Midnight. Review of Resident #29's medication administration audit report documented that the resident's vital signs scheduled for 8:00 AM was documented as completed at 11:11 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 11/21/24 at 10:20 AM, an interview was conducted with Staff H, RN who stated she had 10 residents assigned to her on the south unit and one resident on the north unit. Staff H was asked if she had any resident in the nursery assigned to her and replied No. On 11/21/24 at 10:23 AM, an interview was conducted with Staff F, RN who stated she had 9 residents on the north unit assigned to her including one resident in the nursery and had one daily medication due to be administered. Staff F stated Resident #28 in the nursery was not assigned to her. On 11/21/24 at 10:46 AM, observation revealed Resident #28 in his crib and disconnected of his continuous feeding pump. On 11/21/24 at 10:47 AM, an interview was conducted with Staff H, RN who stated she did not look at her time sheet for her resident's assignment. Staff H was asked went did she find out that Resident #28 was assigned to her and replied around 10:30 AM. Staff H stated she had not assessed the resident yet and his tube feeding was supposed to be connected at 8:00 AM and added she did not connect it at 8:00 AM and did not know for how long Resident #28 tube feeding was disconnected. Review of Resident #28's clinical record documented an admission on 06/13/24 with a readmission on 10/18/24. Review of Resident #28's 11/21/24 Medication Administration Record (MAR) documented the following: -Gabapentin oral solution 250 mg per 5 ml give 175 mg via G-tube for Seizures three times a day at 1:00 AM, 9:00 AM and 5:00 PM. Review of Resident #28's medication administration audit report documented that Gabapentin scheduled for 9:00 AM was documented as administered at 11:06 AM. -Keppra oral solution 100 mg per ml give 120 mg via G-tube for Seizures two times a day at 9:00 AM and 9:00 PM. Review of Resident #28's medication administration audit report documented that Keppra scheduled for 9:00 AM was documented as administered at 11:06 AM. -Glycopyrrolate Oral Solution give 600 mcg via G-Tube four times a day at 3:00 AM, 9:00 AM, 3:00 PM and 9:00 PM. Review of Resident #28's medication administration audit report documented that Glycopyrrolate Oral Solution scheduled for 9:00 AM was documented as administered at 11:06 AM. -Artificial Tears Ophthalmic solution instill one drop on both eyes tow times a day for dry eyes at 8:00 AM and 8:00 PM. Review of Resident #28's medication administration audit report documented that Artificial Tears Ophthalmic solution scheduled for 8:00 AM was documented as administered at 11:06 AM. -Propranolol oral solution 20 mg/5 ml give 15 mg via G-tube four times a day at 2:00 AM, 8:00 AM, 2:00 PM and 8:00 PM. Review of Resident #28's medication administration audit report documented that Propranolol oral solution scheduled for 8:00 AM was documented as administered at 11:11 AM. -Water flush: give water flush of 102 ml every four hours via G-tube for hydration at 0 hours, 4:00 AM, 8:00 AM, 12:00 Noon, 4:00 PM and 8:00 PM. Review of Resident #28's medication administration audit report documented that water flush scheduled for 8:00 AM was documented as administered at 10:53 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Monitor vital signs every 8 hours at 8:00 AM, 4:00 PM and 12 Midnight. Review of Resident #28's medication administration audit report documented that the resident's vital signs scheduled for 8:00 AM was documented as completed at 11:11 AM. On 11/21/24 at 1:59 PM, an interview was conducted with the Director of Nursing (DON) who was apprised of multiple residents who received their medications late. On 11/21/24 at 2:01 PM, during an interview, the Director of Medical Operations was apprised of medications and assessments delayed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on record review, observations and interviews, facility failed to ensure that the administration of enteral nutrition was consistent with the practitioner's orders for 2 of 3 sampled residents (Resident #7 and #15). The findings included: 1) Review of Resident #7's clinical record documented an admission on 09/26/16 with readmission on 11/13/24. The resident diagnoses included Cerebral Palsy, Restlessness and Agitation, Seizures, Feeding Difficulties, Hypoxic Ischemic Encephalopathy, Tracheostomy Status, Acute Respiratory Failure with Hypoxia, Candidiasis of Skin and Nail, and Sepsis due to Methicillin Susceptible Staphylococcus Aureus. Review of Resident #7 Minimum Data Set (MDS) assessments documented a discharge-return anticipated assessment dated [DATE]. The assessment documented that the resident was dependent on the staff for all activities of daily living (ADLs). Review of Resident #7's care plan titled resident name .relies on enteral feeding for all nutrition and hydration needs due to Short Bowel Syndrome with history of persistent diarrhea underweight status .10/22- significant weight gain x 180 Days, on planned weight gain regimen. Interventions included: Enteral feeding and water flushes as ordered dated 10/30/2024 . Review of Resident # 7's clinical record documented a physician order dated 11/14/24 for FORMULA: Peptamen 1.0, give 70 millimeters (ml) per hour continuously via G-tube (feeding tube) for 24 hours. Physician order dated 11/14/24 documented WATER FLUSH: Give Water 180 ml via G-tube three times a day for Hydration. On 11/18/24 at 11:31 AM, observation revealed Resident # 7 sitting in a wheelchair in the classroom, awake and connected to a Tube feeding pump running at 70 ml/hr. The feeding bag was labeled Peptamen formula and did show the time that was hung, but no nurse initials noted. On 11/19/24 at 2:53 PM, observation revealed Resident # 7 in bed, asleep. Tube feeding pump was beeping and read inactive idle 10 minutes. The resident feeding bag had approximately 175 ml left to be infused, and was not connected to the resident, the bag did not revealed the hanging time. On 11/20/24 at 12:42 PM, a side by side observation and review of the feeding and water infused in 48 hours was conducted with Staff A, Resident Care Manager (RCM). The review revealed that Resident #7 received in 48 hours 2,336 ml of his feeding formula and 720 ml of water flushed. Staff A stated the resident should have had received 3,360 ml of his tube feeding and 1,080 ml of water flush in 48 hrs. The resident did not receive his feeding formula and water flushes as per physician orders. Staff A stated the nurses were educated on how to use the feeding pump. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 12:38 PM, a telephone interview was conducted with the Consultant Registered Dietitian (CRD) and team surveyors. The CRD was asked how she can ensure the resident's caloric needs were met and replied the nurses were to monitor the feeding and that she did spot checks, to make sure the feeding were at the right rate, will ask the nurses during rounds if the residents were tolerating or not the feeding, and physically seen the residents every month. The CRD stated Resident #7 was tolerating the feeding very well. The CRD was apprised of Resident #7 feeding formula 2336 ml infused in 48 hours and 720 ml of water flushed in 48 hours. The CRD stated the resident should have had 3360 ml of his feeding formula and 1080 ml of water flushed in 48 hours. The CRD stated it looks like they (nurses) need education and training. 2) Review of Resident #15, clinical record documented an admission on 02/09/21 and most readmission on 04/19/24. The resident diagnoses included Tracheostomy Status, Dependence on Respirator [Ventilator] Status, Gastrostomy Status, Hydrocephalus, Epilepsy, Failure To Thrive (Child), Congenital Malformation Of Heart, and Feeding Difficulties. Review of Resident #15 MDS quarterly assessment dated [DATE] documented the resident was dependent from the staff to complete the activities of daily living. Review of Resident #15's care plan titled resident name .relies on enteral feeding for all nutrition and hydration needs due to swallowing difficulty. Risk factors include: History of intolerance to multiple formulas, constipation, 10/11- Significant weight loss x 180 Days, care plan initiated on 05/03/21 and revised on 10/31/24. Interventions included: Provide enteral feeding and water flushes as ordered . Review of Resident # 15's clinical record documented a physician order dated 05/02/24- for FORMULA: [NAME] FARM PEDIASURE PEPTIDE 1.5 at 60 ml/hour Continuously via G tube two times a day for Nutrition. Review of Resident #15's physician order dated 05/02/24 documented Water flush at 150 ml every four hours via G-tube for hydration. On 11/18/24 at 11:35 AM, observation revealed Resident #15's tube feeding Pediasure formula running at 60 ml/hour with approximately 350- 375 ml left to be infused. Further observation revealed the feeding bag was not labeled with the hanging time or the nurse initials. On 11/19/24 at 10:12 AM, observation revealed Resident #15's tube feeding bag in his room. Consequently, an interview was conducted with Staff B, assigned Registered Nurse who stated the resident was in the classroom. On 11/19/24 at 10:45 AM, observation revealed Resident #15 sitting in a wheelchair in the classroom. Further observation revealed the resident was not connected to his continuously feeding pump. On 11/19/24 at 12:45 PM, observation revealed Resident # 15 in the classroom, his tube feeding pump was off. On 11/19/24 at 2:47 PM, observation revealed Resident # 15 in his room sitting in a wheelchair and connected to feeding pump, the machine read flushing. The feeding bag was labeled 11/19/24, no hanging time noted and had 200 ml of formula left to be infused. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at 3:48 PM, an interview was conducted with Staff A, RCM who stated her role included all activities of residents from arranging appointments, transportation, rounds with the physicians, care planning meeting quarterly, resident's MDS assessment, revised their care plans, initiate a new care plan, enter physician orders, and follow up on new orders from medical appointments. Staff A stated Resident # 15 was seen by the gastroenterologist today and added a probiotic medication and to continue with the same Tube feedings orders. On 11/20/24 at 4:57 PM, a side by side observation of Resident #15's feeding pump was conducted with Staff A, RCM, who stated the feeding was not connected. Staff A checked the feeding pump infusion history and it showed that the resident received 1,280 ml of his feeding formula in 48 hours and 300 ml of water flushed. Staff A was asked to check feeding and water infusion in the last 24 hour and the pump showed Resident #15 had 779 ml of his feeding infused in 24 hours. Staff A cleared the infused volume. On 11/20/24 at 5:00 PM, an interview was conducted with Staff B, RN who stated she connected Resident #15's to his feeding formula when he came back from the doctors appointment. Staff B was apprised that the resident was not connected to his feeding pump. Staff B replied that the resident was put back in bed and the staff probably disconnected it. On 11/20/24 at 5:14 PM, an interview was conducted with Staff C, CNA who stated Resident #15 was disconnected from his feeding when they put him back in bed around 4:00-4:30 PM together with Staff D, Respiratory Therapist (RT). Unable to determine for how long the resident did not receive his tube feeding. On 11/20/24 at 5:16 PM, an interview was conducted with Staff D, RT who stated she helped Staff C to put Resident #15 back and did not remember the time. Staff D stated she disconnected the resident's from the oxygen reading machine, put the ventilator alarms on silent, before transferring them to bed. Staff D was asked who disconnected the resident from the feeding tube and replied she did not have to call the nurse to disconnect Resident #15 because he was not connected to the feeding tube. On 11/21/24 at 12:45 PM, a telephone interview was conducted with CRD who stated she comes to the facility on ce a week on Wednesday, but what not able to come this week. The CRD confirmed Resident #15's feeding formula order and stated the order was for [NAME] FARM PEDIASURE PEPTIDE 1.5 at 60 ml/hour Continuously via G tube two times a day for Nutrition and water flush of 150 every four hours. The CRD stated she had not heard about any issues with the resident feeding and added the resident was tolerating the feeding well. The CRD stated that in 24 hours Resident should have received 1440 ml (60 ml x 24 hours) that provides 2160 calories and water flush of 150 ml x 6= 900 ml. The CRD was apprised that on 11/20/24 around 5:00 PM the feeding pump history was checked with Staff A and it showed the resident received 1280 ml of his formula in 48 hrs and 300 ml of water flushed. The CRD was apprised of concerns related to resident's feeding formula infusion not been administered as per physician orders. The CRD stated the facility got new feeding pumps and everyone was trained and added, sounds like they (nurses) are going to need some education and training.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to 1. Assess residents for the use of bed rails and 2. Obtain informed consent for the use of bed rails for 2 of 2 residents reviewed for bed rails, Residents #10 and 130. The findings included: The facility's policy, 'Safety Measures and Equipment in the Pediatric Unit' most recently revised February 2024, documented: An appropriate size bed or crib will be selected for each resident according to their age and needs. Side rails on all cribs/beds of all residents will be in the up position and securely fastened at all times, unless someone is actually with the resident. 1). Resident #10 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, an Annual Minimum Data Set (MDS), date 10/17/24, Resident #10 was not assessed for cognition due to 'Resident is rarely/never understood'. The MDS documented that the resident was dependent upon staff for activities of daily living (ADLs). Resident #10's diagnoses at the time of the assessment included: Atrial fibrillation, Hypertension, GERD, Aphasia, Quadriplegia, Seizure disorder, Cellulitis, Ventricular fibrillation, Cardiac arrest, Cutaneous Abscess, Disorders of bone density and structure, TBI, Epilepsy, Contracture of ankle Resident #10's care plan for ADLs, initiated on 08/29/19, documented, Resident has ADL Self Care Performance Deficit related to gunshot wound to the head. The goal of the care plan was documented as, Resident will receive appropriate care in Bed Mobility, Transfers, Dressing, and Personal Hygiene through the review date. Interventions to the care plan included; o SIDE RAILS: One side of rails up as per Dr.s order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN to avoid injury. Resident #10's care plan for side rails/falls, initiated on 07/27/20, documented, Use of full rails for safety and risk for injury/falls. The goal of the care plan was documented as, Resident will have no falls during the period under review. Interventions to the care plan included: o Side rails up whenever resident is in bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident #10's health records revealed: Resident with no physician's orders for bed rails. Resident with no assessment regarding the use of rails. Resident with no informed consent for the use of rails. 2). Resident #130 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly MDS, dated [DATE], Resident #130 was not assessed for cognition due to 'Resident is rarely/never understood'. The assessment documented that Resident #130 was dependent upon staff for all ADLs, including bed mobility and transfer. Resident #130's diagnoses at the time of the assessment included: Aphasia, Seizure disorder, and Contracture. Resident #130's care plan for bed rails, initiated 05/24/22, documented, Use of full rails up for prevention of injury to self-characterized by high risk for falls related to disease process and contractures. The Goal of the care plan was documented as, Resident will have no falls. Interventions of the care plan included: o Bed rails used daily with no bed/chair alarms indicated. Further review of Resident #130's records revealed: Resident with no order for the bed rails. Resident with no signed consent for the use of the bed rails. Resident with no assessment for the use of bed rails. During an interview, on 11/22/24 at 12:30 PM, with the Director of Medical Operations and the Administrator, when asked about residents being assessed for the use of the bed rails, the Administrator and the Director of Medical Operations acknowledge that there were none. When asked about not having an informed consent for the use of the bed rails or orders for the bed rails, the Director of Medical Operations stated that it was included in the 'Consent for Treatment'. The Administrator stated, All bed rails are up at all times. All these kids are bed bound. Review of the 'Consent for Treatment' revealed that the use of bed rails was not included.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on observation, interview, and record review, it was determined the medication error rate was 14 percent. Four (4) medication errors were identified while observing a total of 28 opportunities, affecting Resident #27. The findings included: Review of the facility's policy provided by the Director of Nursing (DON) titled Medication Administration and Documentation revised on 03/20/24 documented .medications must be administered in a timely manner and in accordance with the Attending Physician's written/verbal orders .medications .must be administered within one (1)hour of their prescribed time .the individual administering the medication must initial the resident's MAR (Medication Administration Record) .after administering the next resident's medication . Review of Resident #27's clinical record documented an admission on 06/06/24 with a readmission on 08/20/24. The resident Minimum Data Set (MDS) quarterly assessment dated [DATE] documented the resident was dependent on the staff for all the activities of daily living. Resident #27's diagnoses included Acute Respiratory Failure, Tracheostomy Status, Diabetes Insipidus, Anoxic Brain Damage, Convulsions, Gastrostomy status, Retinopathy, Disease of the Stomach and Duodenum and Dependence on Ventilator. Review of Resident #27's physician order documented the following: *08/20/24- Phenobarbital Oral Solution 20 MG/5ML (Phenobarbital) Give 14.8 mg via G-Tube two times a day related to Anoxic Brain Damage, Unspecified Convulsions, give 3.7ml = 14.8 mg. *08/21/24- Propranolol HCl Oral Solution 20 MG/5ML (Propranolol HCl) Give 0.4 ml via G-Tube every 12 hours for blood pressure, give 0.4ml = 1.6mg. *08/20/24- Simethicone Drops Infants Oral Suspension 20 MG/0.3ML (Simethicone) Give 0.3 ml via G-Tube four times a day for Flatulence use 20mg/0.3ml, give 0.3ml= 20mg. *08/20/24- Eye Lubricant Ophthalmic Ointment (White Petrolatum-Mineral Oil). Instill 1 application in both eyes every 4 hours for lubrication. Review of Resident #27's November 2024 Medication Administration Record (MAR) documented the following: * Phenobarbital Oral Solution 20 MG/5ML (Phenobarbital) Give 14.8 mg via G-Tube two times a day related to Anoxic Brain Damage, Unspecified Convulsions, give 3.7ml = 14.8 mg scheduled to be administered at 9:00 AM and 9:00 PM. *Propranolol HCl Oral Solution 20 MG/5ML (Propranolol HCl) Give 0.4 ml via G-Tube every 12 hours for blood pressure, give 0.4ml = 1.6mg scheduled to be administered at 8:00 AM and 8:00 PM. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Simethicone Drops Infants Oral Suspension 20 MG/0.3ML (Simethicone) Give 0.3 ml via G-Tube four times a day for Flatulence use 20mg/0.3ml, give 0.3ml= 20mg scheduled to be administered at 3:00 AM, 9:00 AM, 3:00 PM and 9:00 PM. *Eye Lubricant Ophthalmic Ointment (White Petrolatum-Mineral Oil). Instill 1 application in both eyes every 4 hours for lubrication scheduled to be administered at 0000 hours, 4:00 AM, 8:00 AM, 12:00 noon, 4:00 PM and 8:00 PM. On 11/21/24 at 9:37 AM, medication administration observation for Resident #27 performed by Staff G, Registered Nurse (RN) started. Staff G stated she was late giving the resident's medications. Staff G stated that the residents' medication screen turns red one hour after the scheduled time. Staff G stated usually there were two nurses working in the nursery. Observation revealed Resident #27's medication administration record screen turned red. Staff G proceeded to poured the following medications: *Propranolol 20 mg/5 ml (milligrams per millimeters) filled a syringe with 0.4 ml. Staff G stated the medication was scheduled for 8:00 AM. *Artificial Tears- eyes lubricant. Staff G stated the medication was scheduled for 8:00 AM *Phenobarbital 20 mg/5 ml filled a syringe with 3.7 ml. Staff G stated the medication was scheduled for 9:00 AM. *Simethicone drops 20 mg filled a syringe with 0.3 ml. Staff G stated the medication was scheduled for 9:00 AM. Continue medication administration observation at 10:00 AM, Staff G proceeded to administered the resident's medications. At 10:16 AM, Staff G, RN stated she completed Resident #27's medication administration. On 11/21/24 at 1:59 PM, an interview was conducted with the Director of Nursing who was apprised of multiple residents medication given late.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36057 Based on observation, interview and review of policy and procedure, the facility failed to: 1) ensure that it secured Medication cart #1 (south unit). 2) ensure that it secured the Respiratory Therapy Cart in the north unit. 3) ensure that expired biologicals were removed from the medication room and the crash cart located in the south unit. 4) ensure opened medications bottle were label properly . 5) ensure resident's medications temperature were keep at appropriate temperature. 6) ensure that resident's medications were properly disposed of in the south unit and in the nursery. The findings included: Review of the facility's provided Medication Storage and Labeling Centers For Medicare and Medicaid Services (CMS) form 20089 dated ,d+[DATE] by the Director of Nursing (DON) documented medications and biologicals in medication rooms, carts .were maintained within: secured (locked) locations, accessible only to designated staff . Review of the facility's policy provided by the DON titled Destruction of Medications revised on [DATE] documented unless otherwise instructed, flush tablets, capsules, liquids .down the toilet in the medication room . 1) On [DATE] at 12:27 PM, observation revealed an unlocked medication cart in south unit parked in a common hallway, by resident room [ROOM NUMBER], the cart was unattended. Subsequently, at 12:30 PM, observation revealed Staff B, Registered Nurse (RN) assigned to the medication cart, coming out of room [ROOM NUMBER], two doors down where the medication cart was parked. Staff B walked by the unlocked cart and did not lock it, discarded a tray in the trash can next to the cart, entered the bathroom across the unlocked med cart, came out of the bathroom, and did not lock the cart. Staff B then proceeded to enter room [ROOM NUMBER], came out of room [ROOM NUMBER], walked by her unlocked med cart. At 12:32 PM, observation revealed Staff B walked by the unlocked medication cart and locked it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On [DATE] at 9:40 AM, observation revealed an unlocked Respiratory Therapy cart parked in a common hallway by resident room [ROOM NUMBER], north unit, the cart was unattended. The surveyor was able to open the cart's first drawer (photographic evidence). Subsequently, observation revealed Staff I, Certified Respiratory Therapist (CRT) walked up to the cart and said, who open the cart, I locked the cart. Staff I was apprised the cart was unlocked and surveyor was able to opened the drawer. Staff I stated the cart was assigned to her and was supposed to be locked at all times and did not know who opened it. On [DATE] at 9:43 AM, a side by side observation/review of the facility's north Respiratory Therapy cart was conducted with the DON. During an interview, the DON stated the cart should be locked at all times . The following residents medications were observed in the cart: *Albuterol inhalation solution 2.5 mg/3m *Budesonide 0.5 mg inhalation therapy *Sodium chloride 3% vials *Flonase inhalers *Ventolin inhaler. 3) On [DATE] at 10:02 AM, a side by side review of the facility medication room was conducted with the DON. The review revealed the following expired items: *Four (4) BD vacutainer- serum with an expiration date on [DATE]. *Four (4) blood cultures container with an expiration date on [DATE]. *One (1) blood cultures container with an expiration date on [DATE]. *One (1) blood cultures container with an expiration date on [DATE]. *One (1) 1000 millimeters (ml) Lactated Ringers Injection IV (intravenous) with an expiration date on , d+[DATE]. *38 BD microtainers with an expiration date on [DATE]. On [DATE] at 10:37 AM, an interview was conducted with the DON who was asked who was in charge of checking the medication room for expired items and replied he assumed it was the previous Resident Care Manager but he will be doing it from now on. On [DATE] at 10:53 AM, an interview was conducted with Staff B, RN who stated that the previous Resident Care Manager used to check the medication room for expiration dates. 4) On [DATE] at 12:18 PM, a side by side review of the south unit treatment cart was conducted with Staff B, RN. The review revealed the following: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Two (2) bottles of Hydrogen Peroxide and one (1) bottle of betadine opened and not date. During the review, Staff B stated every opened bottle had to be dated. 5) On [DATE] at 12:28 PM, a side by side observation/review of the south unit medication cart was conducted with Staff B, RN. The review revealed a plastic bin with two ice packs and resident specific medication bottles in it. An inquiry was made about the medications in a bin with ice packs, Staff B stated she brought those medications out of the refrigerator for administration and that she was ready to put them back in the refrigerator. Further observation revealed the ice packs were partially thaw out and there was some clear liquid on the bottom of the bin. Consequently, at 12:38 PM, the following medications room temperatures were checked with the facility's thermometer handled by the kitchen Cook: *Resident #7's Omeprazole 2 mg/ml give 40 mg; medication temperature reading was 50 Fahrenheit degree. *Resident #19's Gabapentin 250 mg/5 ml, medication temperature reading was 60 Fahrenheit degree *Resident ##25-Gabapentin 250 mg/5 ml, medication temperature reading was 63 Fahrenheit degree. On [DATE] at 12:46 PM, during the review, Staff B, RN stated she brought the whole tray, which is kept in the refrigerator with residents medications, out of the refrigerator to be given around 10:00 AM. Staff B stated she administered Resident #7's Omeprazole 2 mg/ml at 8:43 AM today. Staff B stated Resident #19's Gabapentin 250 mg/5 ml was scheduled for 2:00 PM and Resident #25-Gabapentin 250 mg/5 ml was scheduled for 3:00 PM. The review revealed Resident #7, #19 and #25 medications that needed to be kept in the refrigerator, were kept out of refrigeration temperature from 10:00 AM until 12:59 PM. On [DATE] at 12:59 PM, observation revealed Staff B placed the medications back in the refrigerator. 6) On [DATE] at 12:50 PM, observation revealed Staff B, RN flushed approximately 20 ml of Omeprazole and approximately 60 cc of Gabapentin in the hallway/common toilet. During an interview, Staff B stated she flushed the liquid medications in the toilet because she did not have anything else to discard them in. 7) On [DATE] at 9:37 AM, observation revealed a white round pill in a medication cup on top of the medication cart while Staff G, RN was preparing Resident #27's medications. Further observation revealed Staff G, RN discarded the white round pill into the regular trash can located in a main hallway of the nursery. During an interview Staff G was asked for the process of discarding the residents medications and stated she will discard it in the sharp container. Staff G was asked why she discarded the white round pill in the regular trash, she replied she did not remember where she discarded the medication. Consequently, photographic evidence was shown to Staff G. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:59 PM, an interview was conducted with the Director of Nursing (DON) who confirmed the facility's policy related to medication storage was the CMS form provided and stated he will find out if the information given was correct. The DON stated he spoke with the Consultant Pharmacist who informed him that the medications kept in the medication refrigerator, whould be maintained at a temperature between , d+[DATE] Fahrenheit degree. The DON did not provide the medications pharmaceutical information as requested on [DATE] related to the medications temperature. On [DATE] at 4:02 PM, during an interview, the DON was asked for the facility's procedure to discard medications and stated medications destruction is done with the Pharamcist and added nothing, medications wise, should never go into a regular trash can. The DON was apprised of findings. 38349 8) During an observation conducted on [DATE] at 3:25 PM of the red crash cart located on the South wing side hallway, it was observed that there were five (5) over-the-counter (OTC) stock packets of lubricant jelly with an expiration date of [DATE] and two (2) packets of lubricant jelly with an expiration date of [DATE]. (Photographic Evidence Obtained). During an interview conducted on [DATE] at 3:31 PM with Staff J a Licensed Practical Nurse (LPN), regarding the observation of the seven (7) expired, OTC lubricant jelly packets dated [DATE] and [DATE], respectively. Staff J stated that she was not exactly sure who was responsible for checking the expiration dates of the contents of the crash cart; she went on to say that this cart is used by both Therapist and Nurses. She ended by saying that all of the staff are supposed to check for expiration dates. 9) On [DATE] at 1:01 PM during a walking round tour conducted of the North unit, it was observed that there was an unattended, unsecured and unlocked Medication cart on the North unit, accessible to other employees and visitors. On [DATE] at 1:05 PM an interview was conducted with Staff F, a Registered Nurse (RN), inquiring about the unlocked, unsecured and unattended Medication cart, and she revealed by saying, I had just gone into the resident's room for just a minute. During an interview conducted with both the DON and with the Director of Medical Operations, they both recognized and acknowledged that on [DATE] at 11:35 AM, the seven (7) packets of expired OTC lubricant jelly, should have been promptly discarded. During a subsequent interview conducted on [DATE] at 10:28 AM with the Director of Medical Operations, she recognized and acknowledged that the Medication carts should be kept secured at all times; this was not done.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to ensure that the day to day kitchen operations were overseen by a qualified nutrition professional. This has the potential to affect all residents that eat foods prepared in the kitchen. The census at the time of the survey was 29 residents, with 3 that eat from the kitchen. The findings included: The Facility Assessment, dated June 2024, documented: Additional References to the Facility Assessment: Food and Nutrition Services - Staffing. The facility must employ sufficient staff members with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. Resident #17 was admitted to the facility on [DATE]. Resident #17's diet orders included: GIVE PUREED DIET WITH THIN LIQUIDS FOR BREAKFAST, LUNCH AND DINNER. NURSING TO RECORD % CONSUMED - three times a day - 08/25/24. During an observation of lunch being served in the classroom, on 11/18/24 at 12:15 PM, Resident #17 was served pureed broccoli, pureed chicken and puree pasta. It was noted that all three food items pooled on the plate, all three food items were sitting in water from being pureed and the chicken and the broccoli were 'chunky' and not smooth. It was noted that all three pureed food items did not hold the shape of the scoop that was used to portion the food items. During an observation of Resident #17 having breakfast, on 11/20/24 at 8:46 AM, it was noted that Resident #17 received pureed Cream of wheat that was served in a bowl, pureed pancakes and pureed sausage. It was noted that the serving of the pancakes and sausage pooled on the plate around the bowl of cream of wheat. During the follow up kitchen tour, on 11/20/24 at 11:35 AM accompanied by the Food Service Manager and Staff O, Cook, when this Surveyor after observing a regular portion of pork being plated, requested the weight of a serving of the pureed pork. The Food Service Manager and Staff O were unable to locate an appropriate sized scoop to portion the pureed pork. The Food Service Manager stated that there were no additional scoops of the appropriate size for any of the remaining food items that required 4 ounces/half cup, as dictated by the approved menu. The Food Service Manager stated that the Activities staff come to the kitchen and remove scoops to use when there was a food based activity. During the tour, the Food Service Manager confirmed that he was responsible for Resident #17's lunch on 11/18/24 and breakfast on 11/20/24 (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Activities Director, on 11/20/24 at approximately 12:0 PM, the Activities Director stated that the facility had not provided food-based activities recently. During a follow up interview, on 11/21/24 at 10:00 AM, the Food Service Manager stated that he was not a Certified Dietary Manager (CDM) and further stated that he had two more courses to complete and pass to be CDM and is expecting to further his education to be a Registered Dietitian after completing the requirements for being CDM. During an interview, on 11/21/24 at 12:39 PM, with the Registered Dietitian (RD) by phone, the RD stated that she was in the facility, once per week, usually on Wednesdays and for QAPI meetings. This week is ust an off week. When asked about oversight to the kitchen, the RD replied, right now, the Operations Officer is the oversight for the past few months. I work with her and answer any questions that she may have. I do a monthly report and give it to her. It's like a monthly check - a kitchen audit. Cleanliness, meal service, dining, anything that you would look for in the kitchen regulatory, dish machine three comp, food safety and sanitation and I provide them to her and the Administrator. When asked about oversight to purchasing and receiving, the RD state that she had no oversight to purchasing/receiving. During an interview, on 11/21/24 at 2:17 PM, with the Operations Officer, when asked of her job duties, the Operations Officer replied, supervise therapy, education, transportation, food and nutrition programs, Social Services. When asked about overseeing the kitchen, the Operations Officer replied, I am in charge of the ordering and the budget and making sure that we are using the moneys properly. I work the RD to make [NAME] that the kitchen meets all of the requirements and AHCA requirements for the kitchen. We do walk-throughs together and she gives me a weekly report. I supervise the staff. When asked of qualifications related to food service management, the Operations Officer stated that she had a Bachelors' in SLP and Education.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38893 Based on observations, interviews and record reviews, the facility failed to provide meals consistent with orders for pureed consistency for 1 of 3 residents observed for dining, Resident #17. The findings included: Resident #17 was admitted to the facility on [DATE]. Resident #17's diet orders included: GIVE PUREED DIET WITH THIN LIQUIDS FOR BREAKFAST, LUNCH AND DINNER. NURSING TO RECORD % CONSUMED - three times a day - 08/25/24. During an observation of lunch being served in the classroom, on 11/18/24 at 12:15 PM, Resident #17 was served pureed broccoli, pureed chicken and puree pasta. It was noted that all three food items pooled on the plate, all three food items were sitting in water from being pureed and the chicken and the broccoli were 'chunky' and not smooth. It was noted that all three pureed food items did not hold the shape of the scoop that was used to portion the food items. During an observation of Resident #17 having breakfast, on 11/20/24 at 8:46 AM, it was noted that Resident #17 received pureed Cream of wheat that was served in a bowl, pureed pancakes and pureed sausage. It was noted that the serving of the pancakes and sausage pooled on the plate around the bowl of cream of wheat. During the follow up kitchen tour, on 11/20/24 at 11:35 AM accompanied by the Food Service Manager and Staff O, Cook, the Food Service Manager confirmed that he was responsible for Resident #17's lunch on 11/18/24 and breakfast on 11/20/24 and acknowledged that the pureed foods were not prepared according the recipe and in accordance with the resident's diet.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 38893 Based on interviews and record reviews, the facility failed to ensure an accurate Facility Assessment. The findings included: Review of the Facility Assessment revealed the following: In Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, the Facility Assessment, dated June 2024, it documented, for Food and Nutrition Services: Dietician, Cooks, Dietary Aides. In Section 3.2, Staffing Plan, under Other, it documented: Dietician: 1 Consultant approximately 12 hours per week Cooks: (1) Dietary Aides: (1) The Workforce Profile, documented the Education level/Professional requirement for a Dietician as 'High School Diploma'. There was no indication that there would be a Director of Food and Nutrition Services, or what are the qualifications. During an interview, on 11/21/24 at 4:24 PM with the Administrator, the Staff Coordinator, and the Medical Operations Director, when the inaccuracies in the Facility Assessment were brought to their attention, the Administrator acknowledged that Facility Assessment did not accurately reflect the qualifications of the Dietitian and the requirement and qualifications of a Director of Food and Nutrition Services.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, observation, interview and record review, the facility failed to 1) ensure that it utilized and practiced appropriate Enhanced Barrier Precautions during high contact resident care activities for 6 of 29 sampled residents observed, (Residents #24, #28, #8, #4, and #10); And, 2) failed to ensure that it practiced appropriate hand hygiene while administering eye drops during a Medication Administration Observation for 1 of 5 residents (Resident #27). The findings included: 1) Record review of the un-dated facility policy and procedure titled Routine Practices and Transmission Based Precautions provided by the Director of Nursing (DON) reviewed documented in the Policy Statement: Introduction and purpose: There are two (2) tiers of recommended precautions to prevent the spread of infections in healthcare settings: Standard Precautions and Transmission-Based Precautions. 1. Routine Practices (RP) - Routine practices are based on the premise that all clients/patients/residents are potentially infectious, even when asymptomatic, and that the same safe standard should be used routinely with all clients/patients/residents to prevent exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items and to prevent the spread of microorganisms - The consistent and appropriate use of RP by all health care workers with all clients/patients/residents encounters will lessen microbial transmission in health care settings and reduce the need for additional Transmission-Based Precautions - Healthcare providers MUST ASSESS THE RISK of exposure to blood, body fluids and non-intact skin and identify the strategies that will decrease exposure risk and prevent transmission of microorganisms. Record review of the un-dated facility policy and procedure titled Standard Precautions provided by the DON documented in the Policy Statement: Purpose: It is the intent of this facility that: 1. All resident blood and body fluids will be considered potentially infectious. 2. Standard Precautions are indicated for all residents. Procedure: Barriers Indicated in Standard Precautions .3. Gowns/Aprons - should be worn when there is potential for soiling clothing with blood/body fluids. Record review of the un-dated facility policy and procedure titled Personal Protective Equipment provided by the DON documented in the Policy Statement: .Gowns, Aprons, Lab Coats: All personnel must use gowns, aprons, or lab coats when soiling of the clothing with blood, body fluids, secretions, or excretions is likely to occur during treatments .Procedure: 19. Personnel must wear a gown, apron, or lab coat when performing a task (s) that will likely soil employee's clothing with blood, body fluids, secretions, or excretions. 20. When gowns are used, they must be used only once and discarded into appropriate receptacles located in the room in which the procedure was performed 24. For easy access, gowns, aprons, and lab coats are maintained at: i. Central Supply, j. Nurses' Station, k. Isolation Rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy and procedure titled Components of Standard Precautions provided by the DON reviewed 05/2023 and revised February 2020 in the Policy Statement: Standard Precautions (SP) are a set of infection prevention and control strategies and standards that are designed to protect all clients/Residents/patients from exposure to potential sources of infectious diseases. Routine practices are based on the premise that all blood, body fluids, secretions, excretions, mucous membranes, non-intact skin or soiled items are potentially infectious. The incorporation of RP into daily practice by all healthcare providers will help in the protection of both clients/Residents/patients and healthcare providers Sufficient, easily accessible and appropriate PPE .Gown: protects against soiling of clothing during activities that may generate splashes or sprays of blood, body fluids, secretions and excretions. Apply gown prior to performing such activities. Wear when contamination of clothing with potentially infectious material is possible. Gown should fully over the torso, fit close to the body and cover the arms to the wrists .Putting on and taking off personal protective equipment (PPE): is designed to protect healthcare providers in healthcare settings, from exposure to potentially infectious material, when providing care to Residents; these products protect the skin and mucous membranes of the eyes, nose and mouth from exposure to blood, body and respiratory secretions always put on your PPE before contact with Residents Types and Use of Personal Protective Equipment (PPE): To be effective, routine practices and transmission-based precautions depend on the correct use of Personal Protective Equipment (PPE): gloves, gowns, surgical masks, respirators (i.e. N95), and goggles or face shields. Record review of the facility policy and procedure titled Personal Protective Equipment provided by the DON reviewed 05/2023 documented in the Policy Statement: Procedure: 1. PPE is provided to all associates. Each associate is responsible for knowing where the equipment is kept in the department. 2. The type of protective barrier (s) should be appropriate for the procedure being performed and the type of exposure anticipated. 3. PPE available includes gloves, gowns, or aprons, masks, eye protection, and resuscitation devices. Record review of the facility policy and procedure titled Enhanced Barrier Precautions provided by the DON reviewed 05/24 documented in the Policy Statement: It is the policy of this facility to adhere to the CDC guidelines as related to Enhanced Barrier Precautions (EBPs) to prevent the transmission of multi-drug resistant organisms (MDROs) while promoting resident quality of life by addressing the need for psychological well-being of residents who are colonized with MDROs Background: Enhanced Barrier Precautions (EBPs) is a Centers for Disease Control and Prevention (CDC) recommendation to provide guidance for use of personal protective equipment (PPE) in facilities for preventing the spread of multi-drug resistant organisms (MDROs) .Procedure: .3. The facility will implement enhanced barrier precautions during high-contact resident care activities, examples include: Dressing, bathing/showering, Transferring, Changing linens, Changing briefs or assisting with toileting, device care or use - central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care - any skin opening requiring a dressing. 4. The facility may choose to implement enhanced barrier precautions to include any resident with an indwelling medical device or wound 7. Isolation cart containing appropriate PPE and hand sanitizer will be readily accessible for use 10. All resident (s) will require EBPs (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #28 was admitted to the facility on [DATE] with diagnoses which included Severe Hypoxic Ischemic Encephalopathy, Persistent Vegetative State, Near Drowning and nonfatal Submersion, Quadriplegia, Seizures, Unspecified Asthma with acute exacerbation, Anoxic Brain Damage, Tracheostomy and Gastrostomy Status---Enhanced Barrier Precautions. Resident #28 is medically fragile and totally dependent on staff for care, nutrition and hydration. He had a Brief Interview Mental Status (BIM) of severe impairment. On 06/13/24, 10/18/24 and 11/14/24 the three (3) physician's orders documented Sodium Chloride Inhalation Nebulization Solution 3% 3ml via Tracheostomy every six (6) hours, Albuterol Sulfate Inhalation Nebulization Solution 2.5 mg via Tracheostomy every six (6) hours and Change Tracheostomy monthly and as needed one time a day every month, respectively. During an observation of Resident #28 conducted on 11/18/24 at 11:07 AM, it was observed that . There was one (1) Respiratory therapist assigned, Staff I, who was observed working with Resident #28 and she was providing respiratory care, which involves Trach Care, Breathing Treatments and suctioning. All provided/performed without wearing appropriate PPE/gowns, while doing so on 11/18/24 at 11:07 AM. During an interview conducted on 11/19/24 at 9:58 AM with Staff I, regarding the lack of routine application of PPE/gowns when performing hands-on respiratory care for: Resident #28. Staff acknowledged that appropriate PPE/gowns should be worn every time when engaged with high contact resident care activities. And, she revealed and acknowledged that she was not wearing a yellow gown while providing respiratory therapy treatments, when she should have been. Record review of the Resident #28's Care plan initiated 06/17/24 indicated Focus: Child has a Tracheostomy related to disease process. Interventions: . Use universal precautions. Assist with coughing as needed .Goal: Child will have clear and equal breath sounds bilaterally through the review date. He will have no abnormal drainage around tracheostomy site through the review date. He will have no signs and symptoms of infection through the review date. 4) Resident #8, was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Primary Pulmonary Hypertension, Chronic Respiratory Failure, Diabetes Mellitus Type 1, Dependence on Respirator and Gastrostomy Status, Enhanced Barrier Precautions. She had a Brief Interview Mental Status (BIM) of severe impairment. On 01/30/24 the physician's order documented for feeding: Glucerna 1.0 at 40/hour via Jejunostomy-(J) tube continuously, two (2) times a day for Diabetic formula related to Type 1 Diabetes Mellitus. During an observation of Resident #8 conducted on 11/18/24 at 4:26 PM, Staff K, RN was observed providing Gastrostomy (G)-tube care/flushing for Resident #8, without wearing a yellow protective gown. Staff K was also observed stuffing dirty gloves into and atop, an already overflowing/over-stuffed medication cart trash bin full of PPE/gloves and other, discarded trash items multiple times, without washing his hands in between, as he was observed continuing to provide G-tube care and flushing, the entire time, for a minimum of 15 minutes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was conducted with Staff K on 11/20/24 at 3:37 PM regarding the observed lack of routine application of PPE/gown when he performed hands-on care for Resident #8 on 11/18/24 at 4:26 PM, and during the interview he immediately revealed and acknowledged that he was not wearing a yellow protective gown, while providing G-tube care for this resident. Staff K added that he usually does not wear one unless there is going to be splatter. A side-by-side record review was conducted with the Director of Medical Operations, in which it was noted and she verbally indicated that there were two (2) official in-services conducted on the dates of 08/20/24 and 08/21/24 in order to implement the EBP; however, there was no evidence to show that this practice had been fully and appropriately demonstrated and carried out by facility on a daily, regular basis, at the start of this survey. During an interview conducted on 11/19/24 at 11:45 AM, with the Director of Medical Operations, she was asked about the precaution practices utilized by this facility, she responded by saying that, the facility utilizes generalized precautions vs. (EPB) because of all of the indwelling devices used with the kids making it difficult for the staff to distinguish the two, along with the Medical Director. She also revealed that this has been a new/gray area as it relates to instituting the EBP prior to August 2024, for the facility; she added that they just started doing in-services on that recently. On 11/19/24 at 12:13 PM, an interview was conducted with Staff A, a Registered Nurse/Resident Care Manager, (RN/RCM), in which she indicated that all residents, in the facility, are on Contact Precautions, due to all of them having some type of indwelling device (i.e. Ventilator/Tracheostomy, Tube Feeding or Catheter). Conversely, on 11/19/24 at 12:18 PM, the Medical Director of Operations, subsequently stated that the residents in this facility were on EBP facility wide; with one (1) resident in the nursery, that is on Contact Precautions. There was no evidence of any identified PPE isolation/EBP carts designated for staff on either the North or South side of the hallway area, outside of the Nursery, for three (3) of the four (4) days of the survey. Furthermore/Moreover, there was no posted signage in the facility for three (3) of the four (4) days of the survey to indicate that EBP practices were being put in place and utilized for any of the twenty-nine (29) Babies/Children with the following contact conditions or devices in place: Foley Cath., High contact care and residents with Infections or Colonization with a Centers for Disease Control (CDC), Methicillin Drug Resistant Organisms (MDRO) (when Contact Precautions do not apply), Dialysis, Tracheostomy, or Wound care, etc. In fact, additional PPE supplies, to include disposable gowns, were not brought out and distributed within the facility, from in inventory stock, with facility staff observed as regularly and routinely donning all appropriate PPE (to include yellow gowns), until after surveyor intervention and Inquisition. The DON and the Director of Medical Operations, both recognized and acknowledged that on 11/20/24 at 4:14 PM, that staff should have been wearing PPE/protective yellow gowns while performing high-contact resident care activities, to residents ; this was not done. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	36057 5) Review of the facility policy provided by the Director of Nursing titled Hand Washing/Hand Hygiene revised on 03/20/24 documented All personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections .If hands are not visible soiled, use an alcohol-based rub .for the following situations: .before moving from a contaminated body site to a clean body site during resident care .after removing gloves . Review of the facility policy provided by the Director of Nursing titled Personal Protective Equipment (PPE) dated 03/20/24 documented .wash your hands after removing gloves . Review of the facility policy provided by the Director of Nursing titled Artificial Nails revised on 02/24 documented .length of nails: .short 1/4 inch or less beyond the tip of the finger .long fingernails both artificial and natural, harbor more microorganism than short nails .artificial nails or nails enhancements should not be worn by any person whose responsibilities include .direct hands-on resident contact . 6) On 11/21/24 at 8:01 AM, medication administration observation for Resident #10 performed by Staff F, RN was conducted. Staff F poured the medications and entered the resident's room, performed handwashing, pulled the privacy curtains with a piece of towel paper then donned gloves. Staff F proceeded to check the resident's tube feeding for patency with her stethoscope, flushed the tube feeding with 5 millimeters of water, administered the medications via a G-tube, repositioned the bed sheets, removed gloves, and performed handwashing. During the medication administration observation, it was noted that Staff F did not wear a gown. On 11/21/24 at 9:34 AM, an interview was conducted with Staff F, RN who was asked what her understanding of Enhanced Barrier Precautions was and replied to wear a gown, wear gloves when doing something for the residents, with those who have ventilator, wounds, open area, and a G- tube. Staff F was asked why she did not wear a gown during the administration of medications for Resident #10 who had a G-Tube and a Ventilator and replied she was stressed out but she should wear a gown. 7) On 11/21/24 at 8:49 AM, medication administration observation for Resident #4 performed by Staff H, RN was conducted. Staff H poured the medications and entered the resident's room, performed hand sanitation, and donned gloves. Observation revealed Staff H did not don a gown, proceeded to place her stethoscope on the resident's abdomen. Observation revealed Staff H's uniform was touching the bed's sheet and the under pad. Staff H flushed the feeding tube, administered the resident's medications and flushed the resident's feeding tube. Furthermore, observation revealed Staff H leaned over the bed sheet to place the resident's abdominal binder. (continued on next page)

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