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	04/16/2026

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** Based on observation, interviews and record review, the facility failed to assist a resident with feeding in a manner to promote dignity for 1 of 3 sampled residents that eat by mouth (Resident #20).The findings included: Review of the facility's policy titled, Resident's Rights, dated 01/2026, included the following: Employees shall treat all residents/clients with kindness, respect and dignity.Policy Interpretation and Implementation:3. Our company will make every effort to assist each resident in exercising his/her/rights to assure that the resident is always treated with respect, kindness, and dignity. Record review for Resident #20 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Quadriplegia, C1-C4 Complete; Tracheostomy Status; Dependence on Respirator [Ventilator] Status; Gastrostomy Status; Acute and Chronic Respiratory Failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 has bilateral impairment of upper and lower extremities. The MDS documented that Resident #20 was dependent upon staff for all Activities of Daily Living (ADLs), including eating.Review of Resident #20's Care Plan initiated on 11/25/25, documented Resident #20 required tube feeding for all nutrition and hydration needs related to Dysphagia. Additional risk factors included: Quadriplegia, feeding tube present with water flush only for patency of tube, Seizures, Abnormal labs, Overweight, and a selective eater. The goal of the care plan was documented as, Resident will be free of aspiration through the review date. Interventions included Resident will be fed by staff; Monitor oral intake and weight as ordered; Regular diet with Thin Liquids as ordered by Dietitian. On 04/13/26 at 12:34 PM Staff F, Certified Nursing Assistant (CNA) entered Resident #20's room with the lunch tray. At 12:38 PM it was noted that Resident #20 was in bed and the head of the bed was set to 45 degrees. Staff F was observed standing over at the and left of the resident while assisting with the lunch meal. She was asked if that's the protocol to assist with meals and she stated that Resident #20 likes to sit higher on the bed. She then was asked if the bed can be adjusted up and down, she stated yes. During a medication administration observation conducted on 04/15/26 at 8:30 AM for Resident #20's roommate, it was noted Staff E, CNA, was in the room assisting Resident #20 with the breakfast meal. Further observation revealed Staff E was standing on the right side of Resident #20's bed, the bed was raised to Staff E's waist, and she was feeding the resident. During an interview conducted on 04/15/26 at 11:02 AM with Director of Nursing (DON), she stated she has worked at the facility for over 5 months. She was made aware of the concerns with dignity during dining. She stated that Resident #20 does like his bed elevated and makes it hard for the CNA to feed him sometimes. She stated that the protocol is to sit and feed the kids.During an interview conducted on 04/15/26 at 4:00 PM with Staff E, she stated she has worked at the facility for 6 years. She stated for Resident #20 she assists with his meals and that it is okay and per protocol to stand while assisting him with his meals.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility failed to obtain informed consent for resident receiving psychotropic medication for 2 of 2 sampled residents reviewed for unnecessary medications (Residents #25 and #13). The findings included: 1. Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Anoxic Brain Damage, Dependence on Respirator [Ventilator], Tracheostomy Status, Gastrostomy Status. The Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) was not conducted due to Resident #13 being rarely/never understood and was on the following medication: antianxiety (psychotropic). Review of the Physician's Orders showed that Resident #13 had orders for the following medication: 11/12/25 for Diazepam (antianxiety) 10 milligram (mg) tablet to give 10 mg via G-Tube four times a day for Seizure. Record review of Resident #13's electronic and paper medical chart revealed no informed consent for administration of the above medication. 2. Record review for Resident #25 revealed the resident was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Tracheostomy Status, Dependence on Respiratory (Ventilator) Status, and Other Epilepsy and Recurrent Seizures. Review of the Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status was not conducted due to the resident is rarely/never understood. Review of the Physician's Orders or Resident #25 revealed an order dated 03/23/26 for Diazepam (a psychotropic medication) oral solution 5 MG\/5ML Give 3 ml via J-Tube three times a day. Record review for Resident #25 revealed no informed consent for psychotropic medications. During an interview conducted on 04/15/26 at 1:15 PM with Staff D Registered Nurse who was asked about residents who are ordered psychotropic medication(s) do they obtain informed consent, she said yes and it would be filed under the miscellaneous tab in the electronic medical record for the resident. During an interview conducted on 04/15/26 at 2:00 PM with the Director of Nursing (DON) who was asked about residents who receive psychotropic medications if the resident or resident representative need to provide informed consent, she said yes and it would be documented under miscellaneous tab in the residents' electronic medical record. She added they would only obtain additional informed consent if the dosage was increased or if the medication was being changed.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide funds in a timely manner after receiving a request for personal funds. This affected 1 of 1 sampled Resident (Resident #26), who was reviewed for personal funds. The findings included:Record review of the Policy on Individual Accounting Records of Resident Funds last reviewed October 2017 stated that all resident's requests for expenditures were to be prepared and signed by the Social Worker and approved by the Administrator. The expenditure invoices were to be sent to the Accountant for verification and approval. After that, the Accounting Manager would issue a check to be signed by the Chief Executive Officer and the Chief Medical Operations Officer. Record review revealed Resident #26 was admitted to the facility on [DATE]. A comprehensive assessment dated [DATE] documented Resident #26 had a diagnosis of Quadriplegia. The assessment also documented that Resident #26 had a Brief Interview for Mental Status (BIMS) score of 15. This indicated Resident #26 was cognitively intact. The assessment documented that Resident #26 had clear speech and was able to express his ideas and his wants in order to make himself understood. An interview was conducted during the initial screening process, on 04/13/26 at 12:35 PM. Resident #26 explained that he was paralyzed. He said he used his voice to speak in a microphone to call for assistance when needed. When asked if there were any areas of improvement that the facility should make, Resident #26 said they should give residents their money when they ask for it. He explained he emailed the Social Worker and requested a check on 12/23/26. He said that wasn't the first time he experienced a long wait time to get funds after requested. When asked how he was affected by the delay in receiving money, Resident #26 said he had a plan to do something with the money and now he had to wait. Record review revealed documentation that confirmed a request for $300 was emailed to the Social Worker on 12/23/2025 at 4:10 AM. The response from the Social Worker sent on 12/23/25 at 9:57 AM said that his check would be ready next week. (Photographic Evidence Obtained). A grievance about Resident #26's unfulfilled request for funds was filed on 03/17/26 after the Social Worker received an email from the Regional Ombudsman's Manager. Record review of the Social Services Progress notes in the electronic medical records dated 04/10/26 documented two conversations about the requested check. It noted that the Social Worker, Resident #26, and the resident's first contact/caregiver discussed the status of the funds at the previous care plan and then again one week later. The progress note documented that the requested check was still pending. An interview with the Social Worker on 04/16/2026 at 10:34 AM confirmed that Resident #26 did not receive the check that he requested on 12/23/26. She added, he should hopefully receive it next week.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure advance directives (code status) are clearly documented in the medical record for 2 of 6 sampled residents reviewed for advanced directives (Resident #25 and Resident #20). The findings included:Review of the facility's policy titled, Advance Directives with a revised date of 03/2026 included in part the following: Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. The Interdisciplinary Team will review annually with the resident his or her advanced directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS). 1. Record review for Resident #20 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Quadriplegia, C1-C4 Complete; Tracheostomy Status; Dependence on Respirator [Ventilator] Status; Gastrostomy Status; Acute and Chronic Respiratory Failure. Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #20 has bilateral impairment of upper and lower extremities. The MDS documented that Resident #20 was dependent upon staff for all Activities of Daily Living (ADLs), including eating. Review of Resident #20's electronic medical record revealed no documentation for advance directive including code status orders from the physician. Further review of the resident's paper chart located at the nurses' station revealed no documentation or order for code status. 2. Record review for Resident #25 originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Tracheostomy Status, Dependence on Respiratory (Ventilator) Status, and Other Epilepsy and Recurrent Seizures. Review of the Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status was not conducted due to the resident is rarely/never understood. Review of the Physician's Orders for Resident #25 revealed no order to address the resident's code status. 3. Record review for Resident #28 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Obstructive Hydrocephalus, Tracheostomy Status, Presence of Cerebrospinal Fluid Drainage Device and Unspecified Lack of Expected Normal Physiological Development in Childhood. Review of the Physician's Orders for Resident #28 revealed no order to address code status. During an interview conducted on 04/15/26 at 1:15 PM with Staff D Registered Nurse (RN) who was asked about advance directives including a code status, she said there should be an order in the chart. If there is no order, they would presume the resident is a full code. When asked about Resident #25 and #28 she acknowledged there was no order for either resident for code status. During an interview conducted on 04/15/26 at 1:40 PM with Staff B Social Worker who stated she has worked at the facility since September 2024. When asked when is advance directives, including code status discussed with the resident or the resident representative, she said on admission she will (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide them with the admission Agreement and the facility's policy on Advance Directives and will discuss the code status for the resident. She does not document the specifics about advanced directives. When asked who puts in the orders for the code status either DNR or full code, she said that she would be the Director of Nursing or the admitting nurse. During an interview conducted on 04/15/26 at 2:00 PM with the Director of Nursing (DON) who was asked if they would need an order for the code status, she said only if they are a DNR (Do Not Resuscitate). If there is no order for DNR then they are presumed to be full code and would treat the patient as such.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to inform physician/family of change in condition for 1 of 1 sampled resident reviewed for change in condition (Resident #7). The findings included:Review of the facility's policy titled. Change in a Resident's Condition or Status with a revised date of 10/2025 included in part, the following: Our facility will promptly notify the resident, attending physician, and representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). The Director of Nursing (DON)/designated Nurse will notify the resident's Attending Physician when there has been: A need to transfer the resident to a hospital/treatment center. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical /mental condition status. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted. The Social Worker or DON will notify the resident, his/her family, or representative when there is a change in the resident's level of care status. Record review for Resident #7 revealed the resident was originally admitted to the facility on [DATE] and was sent to the hospital 3 times between 03/10/26 and 03/30/26 with diagnoses that included in part the following: Asthma, Preterm Newborn Gestational age [AGE] Completed Weeks, Respiratory Failure of Newborn, Gastrostomy Status, Tracheostomy Status, Dependence on Respiratory (Ventilator) Status. Review of the Minimum Data Set assessment dated [DATE] Section C documented a Brief Interview of Mental Status was not conducted due to resident is rarely/never understood. Review of the Nurse's Notes for Resident #7 dated 03/10/26 documented in part the following: Patient alert and awake. Patient's GJ tube (J-port) found to be obstructed; feeding pump alarms, 10 ml water flush met with high resistance. No formula or gastric contents returning. Extension part was remove and flushed. Feeding pump was checked for malfunction. Flushed port directly. When extension attached resistance was met. Director of Nursing notified. Mom at bedside made aware of the problem. Order received to send patient to hospital. In summary, it was not clear whether the physician notified of the change in condition or if the order to transfer the resident out of the hospital came from the physician or the DON. Review of assessments for Resident #7 revealed no change in condition assessment completed for 03/10/26. Review of the Nurse's Notes for Resident #7 dated 3/17/26 documented in part the following: Patient on ventilator support. Desaturation noted to 62% accompanied by tachycardia. Respiratory therapist was notified and intervened promptly. Patient was suctioned, manually bagged and received respiratory treatment. Oxygen saturation improved but remained between 85-89%. DON was notified and provided order to transfer patient via emergency services. 911 called and patient was transported at 11:53am with paper work. Report given to the emergency room nurse at hospital. In summary it was not documented that the physician nor the family was notified of the change in condition for Resident #7 requiring a higher level of care. Review of the progress notes for Resident #7 revealed no nurses notes dated 03/30/26. Review of assessments for Resident #7 revealed no change in condition assessment completed for 03/30/26. Review of the Physical Therapist and Occupational Therapist note for Resident #7 dated 03/31/26 documented: Patient unavailable for therapy - currently hospitalized . In summary for Resident #7 on 03/30/26 there was no documentation of what the circumstances were or if the physician or family was notified of the change in condition requiring the resident to be sent out to the hospital for a higher level of care. During an interview conducted on 04/15/26 at 1:15 PM with Staff D, Registered Nurse, who was asked about when a resident has a change in condition, she said they will call the DON. The doctor will usually give the orders and then we document in a progress note the situation. The nurse or the DON will notify the family and that is documented in a progress note as well. During an interview conducted on 04/15/26 at 1:30 PM with Staff C Registered Nurse who was asked about (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when a resident has a change in condition, she said they will call the DON. The DON will call the physician. The nurse will notify the family; everything is documented in a progress note. During an interview conducted on 04/15/26 at 2:00 PM with the Director of Nursing (DON) who was asked about a change in condition when and who would be notified, she said the nurse would notify the DON for non-emergency issues, or the Physician or Nurse Practitioner for all other issues. They only notify the family if the resident is sent out for a higher level of care or any emergency situation they could not treat in the facility. For instance, they would not notify the family each time a resident had a seizure if the resident has chronic seizures. They would notify the physician only if it was something that could not be mitigated here at the facility.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to develop a baseline care plan for 1 of 13 sampled residents, (Resident #2) reviewed for Baseline Care Plans. The findings included: Record review revealed Resident #2 was admitted to the facility on [DATE]. His diagnoses included Gastrostomy Status (a surgical opening in stomach for a feeding tube), and Failure to Thrive. Record review of the electronic medical records for Resident #2 was conducted on 04/16/26 at approximately 10:45 AM. A search for a baseline care plan that should have been completed within the first 48 of admission to the facility was conducted. No baseline care plan was found. An interview was conducted with the Director of Nursing on 04/16/26 at approximately 10:55 AM. The DON was asked if she could show the surveyor the baseline care plan for Resident #2. The DON said she would call the MDS coordinator and ask her if she could locate a baseline care plan for Resident #2 (the Minimum Date Set coordinator worked remotely). On 04/16/26 at approximately 11:15 AM, the DON explained that she spoke to their MDS coordinator who said that we used a lookback period of 7 days, and that's what we use for our baseline care plan. The DON confirmed that there was no 48-hour baseline care plan for Resident #2.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included advanced directives for 6 of 6 sampled residents reviewed for advance directives (Resident #2, Resident #4, Resident #7 Resident #25, Resident #28 and Resident #20) and failed to develop an implement a comprehensive person-centered care plan for each resident that included psychotropic medications for 2 of 28 sampled residents receiving psychotropic medications (Residents #13 and #25). The findings included:1. Record review for Resident #20 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Quadriplegia, C1-C4 Complete; Tracheostomy Status; Dependence on Respirator [Ventilator] Status; Gastrostomy Status; Acute and Chronic Respiratory Failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 has bilateral impairment of upper and lower extremities. The MDS documented that Resident #20 was dependent upon staff for all Activities of Daily Living (ADLs), including eating. Review of Resident #20's electronic medical record revealed no formulation of an advance directive or documentation of an order for code status from the physician. Further review of the records revealed Resident #20's care plan for advance directive was not developed. 2. Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Anoxic Brain Damage, Dependence on Respirator [Ventilator], Tracheostomy Status, Gastrostomy Status. The Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) was not conducted due to Resident #13 being rarely/never understood and was on the following medications: antianxiety (psychotropic), anticoagulant and anticonvulsant. Review of the Physician's Orders showed that Resident #13 had orders for the following medications: Valproic Acid Solution (anticonvulsant/hypnotic) 250 milligrams (mg)/5 milliliters (ml), to be give 1 gram via G-Tube (Gastrostomy) three times a day for Seizures 1 gram = 20 ml, dated 11/09/24; Levetiracetam Solution (anticonvulsant) 100 mg/ml, to give 15 ml via G-Tube two times a day for seizure 15 ml = 1500 mg, dated 08/25/25. In addition, an order dated 11/12/25 for Diazepam (antianxiety) 10 mg tablet to give 10 mg via G-Tube four times a day for Seizure. Review of Resident #13's active and resolved care plans on file revealed that a care plan for the resident psychotropic medications was not developed. 4. Record review for Resident #2 revealed the resident was admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Congenital Hydrocephalus, Extreme Immaturity of Newborn Gestational age [AGE] Completed Weeks, Epilepsy, Presence of Cerebrospinal Fluid Drainage Device and Failure to Thrive. The Minimum Data Set assessment dated [DATE] documented in Section C a Brief Interview of Mental Status was not completed due to resident is rarely/never understood. Review of the Care Plan for Resident #2 revealed no care plan for advance directive or code status. 5. Record review for Resident #4 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following: Cerebral Palsy, Dependence on Respirator (Ventilator) Status, Tracheostomy Status, Cleft Palate, Other Apnea of Newborns, and Myotonic Muscular Dystrophy. The Minimum Data Set assessment dated [DATE] documented in Section C, a Brief Interview of Mental Status was not completed due to resident is rarely/never understood. Review of the Care Plan for Resident #4 revealed no care plan for advance directive or code status. 6.Record review for Resident #7 revealed the resident was originally admitted to the facility on [DATE] and was sent to the hospital 3 times between 03/10/26 and 03/30/26 with diagnoses that included in part the following: Asthma, Preterm Newborn Gestational age [AGE] Completed Weeks, Respiratory Failure of Newborn, Gastrostomy Status, Tracheostomy Status, Dependence on Respiratory (Ventilator) Status. Review of the Minimum Data Set assessment dated [DATE] Section C documented a Brief Interview of Mental Status was not conducted due to resident is rarely/never understood. Review of the Care Plan for Resident #7 revealed no care plan for advance directives or code status. 4)Record review for Resident #25 originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Tracheostomy Status, Dependence on Respiratory (Ventilator) Status, and Other Epilepsy and Recurrent Seizures. Review of the Minimum Data Set assessment dated [DATE] documented in Section C a Brief Interview of Mental Status was not conducted due to the resident is rarely/never understood. Review of the Physician's Orders or Resident #25 revealed an order dated 03/23/26 for Diazepam (a psychotropic medication) oral solution 5 MG/5ML give 3 ml via J-Tube three times a day. Review of the Care Plan for Resident #25 revealed no care plan for advance directives or code status and no care plan for psychotropic medications. 7. Record review for Resident #28 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Obstructive Hydrocephalus, Tracheostomy Status, Presence of Cerebrospinal Fluid Drainage Device and Unspecified Lack of Expected Normal Physiological Development in Childhood. Review of the Care Plan for Resident #28 revealed no care plan for advance directives or code status. An interview conducted on 04/15/26 at 1:40 PM with Staff B, Social Worker, who stated she has worked at the facility since September 2024. When asked if she does the care plans for social services, she said yes but it does not include information about advance directives. When asked about a care plan for advanced directives including the code status, she said in the past that it may have been done by the RCM (Resident Care Manager) but they no longer have anyone in that position. She said she was not trained to do that. When asked if she discusses advance directives (including code status) any time after admission, she said no unless the resident or resident/family approach the facility to change their wishes or if when the resident was out for a hospital stay and the code status was changed while out at the hospital then they would discuss with the resident/family. When asked if they have care plan meetings, she said yes, they are held quarterly and the advance directives are not discussed in the care plan meeting. During an interview conducted on 04/15/26 at 2:00 PM with the Director of Nursing (DON) who was (continued on next page)

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	106110	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked about a care plan for advanced directives including the code status, she said she would not expect to see a care plan unless they had an order for DNR.

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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** Based on interviews and record review the facility failed to document medications administration or document why med not administered for 5 of 13 sampled residents (Resident #2, Resident #28, Resident #5, Resident #25, Resident #13). The findings included:Review of the facility's policy titled, Medication Administration, Documentation, & Storage, dated 07/01/25, included the following: To ensure the safe and appropriate administration, documentation, and storage of medications. Medication Administration:1. Medications must be charted by the person administering the drugs immediately following the administration. Documentation:2. The licensed staff administering medication will document this information on the resident's eMAR (electronic Medication Administration Record), by initiating his/her name in the appropriate box on the specified date and time. 3. If a medication is not administered, the licensed staff will initial the eMAR and the reason why the medication was not administered will be documented. 1. Record review for Resident #2 revealed the resident was admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Congenital Hydrocephalus, Extreme Immaturity of Newborn Gestational age [AGE] Completed Weeks, Epilepsy, Presence of Cerebrospinal Fluid Drainage Device and Failure to Thrive. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status was not completed due to resident is rarely/never understood. Review of the Physician's Orders for Resident #2 revealed in part, the following: 01/28/26 for Cyproheptadine HCl Oral Syrup 2 MG/5ML Give 2 mg via G-Tube one time a day 01/28/26 for Lansoprazole Oral Suspension Give 7.5 mg via G-Tube one time a day 01/28/26 for clonazepam Powder Give 0.0625 mg via G-Tube two times a day An order dated 02/12/26 for levetiracetam Oral Solution 100 MG/ML Give 150 mg via G-Tube two times a day An order dated 03/24/26 for Sodium Chloride Oral Solution 4 MEQ/ML Give 25.2 meq via G-Tube two times a day Review of the Medication Administration Record for Resident #2 from 04/01/26 to 04/12/26 revealed in part the following: On 04/04/26 Clonazepam was not documented as administered or reason why the medication was not administered. On 04/05/25 Clonazepam, Cyproheptadine, Lansoprazole, Levetiracetam and Sodium Chloride all were not documented as administered or reason why the medication not administered. Review of the progress notes revealed no documentation for 04/04/26 or 04/05/26. 2. Record review for Resident #28 revealed the resident was admitted to the facility on [DATE] with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses that included in part the following: Obstructive Hydrocephalus, Tracheostomy Status, Presence of Cerebrospinal Fluid Drainage Device and Unspecified Lack of Expected Normal Physiological Development in Childhood. The Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status was not performed due to the resident is rarely/never understood. Review of the Physician's Orders for Resident #28 revealed no order to address code status. Review of the Care Plan for Resident #28 revealed no care plan for Review of the Physician's Orders for Resident #28 revealed in part the following: 01/06/26; Ferrous Sulfate Oral Solution 220 (44 Fe) MG/5ML (Ferrous Sulfate) Give 110 mg via G-Tube one time a day for nutrition status 110mg=2.5ml 01/06/26: Gabapentin Oral Solution 250 MG/5ML (Gabapentin) Give 85 mg via G-Tube every 8 hours for neuropathic pain 85mg=1.7ml 01/06/26: Metronidazole Oral Tablet 250 MG (Metronidazole) Give 125 mg via G-Tube every 8 hours related to Chron's Disease. 125mg=1/2 tablet 01/06/26: Sucralfate Oral Suspension 1 GM/10ML (Sucralfate) Give 160 mg via G-Tube every 6 hours related to Chron's Disease, 160mg=1.6ml 01/08/26: Senna Oral Syrup (Sennosides) Give 4.4 mg via J-Tube one time a day related to Colostomy Status (Z93.3) 4.4mg=2.5ml 01/09/26: Calmoseptine External Ointment 0.44-20.6 % (Menthol-Zinc Oxide) Apply to perineal wound topically, as needed for perineal wounds, specifically, specifically, and the perineal wound topically every shift related to Crohn's Disease and apply to perineal wound topically as needed for perineal wound 02/09/26: MiraLax Oral Packet 17 GM (Polyethylene Glycol 3350) give 17 gram via J-Tube one time a day related to Colostomy Status. Mix with 4-8 ounces of water. 03/20/26: Cetirizine HCl Oral Solution 1 MG/ML (Cetirizine HCl) give 5 mg via G-Tube two times a day for perennial allergic rhinitis for 30 Days give 5 ml 03/26/26 hydroxyzine HCl Oral Syrup 10 MG/5ML (Hydroxyzine HCl) give 10 mg via G-Tube three times a day for chronic pruritus 10 mg= 5 ml 03/31/26: Peptamen Jr. 85 ml/hr. x 17.5 hours. On at 1800 off at 1130. Water flush 35 ml q 6 hours. Every 6 hours for nutrition 03/31/26: Neocate [NAME]: mix 43 scoops powder into 43 ounces water. Total volume 1500 ml/day. Run at 86ml/hr. x17.5 hours. On at 1800, off at 1130. Water flush of 10ml every 3 hours during feeds. (May substitute with Elecare jr if Neocate is unavailable. Mix according to can, run at same rate.) two times a day until 04/04/2026 23:59 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) from 04/01/26 to 04/12/26 revealed following medications had no documentation of being administered nor any documentation of a code as to why they were not given as follows: On 04/02/26 at 4:00 AM, the medications: Ferrous Sulfate, MiraLax, Senna, and Cetirizine 04/02/26 at 6:00 AM, the medications: Neocate [NAME], Gabapentin, Hydroxyzine, Metronidazole On 04/04/26 night shift, medication: Calmoseptine On 04/09/26 at 6:00 AM, medications: Gabapentin, Hydroxyzine, Metronidazole, Peptamen Jr. and Sucralfate Review of the progress notes from 04/01/26 to 04/12/26 did not document any reason why the above medications were not administered. During an interview conducted on 04/15/26 at 1:15 PM with Staff D Registered Nurse who was asked about administering medications and documentation, she said we as we give the medications we sign off on the MAR, if we do not give a medication you put in a code on the MAR and then document in a progress not the reason why the med is not being given. During an interview conducted on 04/15/26 at 2:00 PM with the Director of Nursing (DON), who was asked about documentation of medications administered, she said she would expect the documentation to be on the MAR (Medication Administration Record), and it would be completed at the time of the medication being given. If the medication was not given for whatever reason, she would expect to see documentation the medication or treatment was not given and the reason why, typically the nurse would enter a code to see the nurse's progress notes and then document in the progress notes the reason why the medication was not given. She said typically the nurse will draw up or prepare the medications and acknowledge them in the electronic record, administer the medication then document the medication as if having been administered or not administered and an explanation in the documentation for the reason not having been administered. 3. Record review for Resident #5 revealed the resident was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Congenital Malformation of Heart; Chromosomal Abnormality; Dependence on Respirator [Ventilator] Status; Gastrostomy Status; Epilepsy and Tracheostomy Status. Review of the April 2026 Medication Administration Record (MAR) for Resident #5 documented the following: Monitor Vital Signs every shift (day and night shift); on 04/12/26 during the night shift no vital signs were documented.Diazepam 5 milligram (mg)/5 milliliters (ml) to be given via G-Tube (Gastrostomy tube), related to Epilepsy, every 6 hours at 0000 (12:00 AM), 0600 (6:00 AM), 1200 (12:00 PM) and 1800 (6:00 PM); Further review revealed on 04/13/26 at 6:00 AM revealed an empty slot (no nurse's initials) on, which indicated the medication was not administered. Record review of the nurses' progress notes for 04/13/26 revealed no documentation as to why Resident #5's medication was not administered, or vital signs were not monitored. 4. Record review for Resident #25 revealed the resident was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Epilepsy and Recurrent Seizures; (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Gastrostomy Status; Gastrointestinal Hemorrhage; Esophageal Varices without Bleeding; Diabetes Mellitus with Hyperglycemia; Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation; Dependence on Respirator [Ventilator] Status; and 2026 Tracheostomy Status. Review of the April Medication Administration Record (MAR) for Resident #25 documented the following medications with slots without a nurse's initial: Clonazepam 2 mg tablet for Seizures to be given via (Jejunal feeding tube (J-Tube) every 12 hours at 0600 and 1800; on 04/13/26 at 0600 revealed medication was not administered.Lantus (Insulin Glargine) solution 100 Unit/ml for Hyperglycemia to inject 30 units subcutaneously every 12 hours at 0600 and 1800; on 04/13/26 at 0600 revealed medication was not administered.Levetiracetam Solution 100 mg/ml for Seizures to give 1000 mg via J-Tube every 12 hours at 0600 and 1800; on 04/13/26 at 0600 revealed medication was not administered.Monitor Vital Signs every shift; on 04/12/26 during the night shift no vital signs were documented. Further review of the MAR listed the following medications. Omeprazole Suspension related to Esophageal Varices without Bleeding, give 15 ml via J-Tube two times a day at 0400 (4:00 AM) and 1600 (4:00 PM); on 04/13/26 at 0400 revealed medication was not administered. Baclofen 10 mg tablet for Spasticity to give 10 mg via J-Tube every 8 hours at 0600, 1400 (2:00 PM), and 2200 (10:00 PM); on 04/13/26 at 0600 revealed medication was not administered.Diazepam Solution 5 mg/5ml for Epilepsy and Recurrent Seizures to give 3 ml via J-Tube three times a day at 0600, 1400, and 2200. on 04/13/26 at 0600 revealed medication was not administered. Chlorhexidine Gluconate Solution 15 ml for oral hygiene to be used with oral care sponge four times a day at 0000, 0600, 1200 1800; on 04/13/26 at 0600 revealed oral care was not done.Insulin Lispro Solution 100 Unit/ml for Diabetes Mellitus to be injected as per sliding scale: if 201 - 250 = 4 units; 251 - 300 = 5 units; 301 - 350 = 6 units; 351 - 400 = 7 units, > 400 = 8 units subcutaneously every 4 hours at 0000, 0400, 0800, 1200, 1600, and 2000; on 04/13/26 at 0400 revealed Blood Sugar (BS) reading was not obtained or medication was not administered. Record review of the nurses' progress notes dated 04/12/26 at 1845 (6:45 PM) documented the following Per report from the night nurse, the resident had a history of seizures associated with delayed medication administration, accompanied by increased heart rate and oxygen desaturation. During care, while assisting the resident with a CNA (Certified Nursing Assistant) for repositioning and changing, the resident began to desaturate and exhibited seizure activity. Oxygen saturation dropped during the episode. This was the first time this writer observed this response during care, despite having cared for the resident previously. Nurse and respiratory therapist were at bedside to monitor the resident. She was closely observed and appropriate interventions were initiated. Record review of the nurses' progress notes for 04/13/26 revealed no documentation as to why Resident #25's medications were not administered; vital signs and BS readings were not monitored; and oral care was not conducted. Review of the nursing schedule revealed Staff H, Registered Nurse (RN), was working the night shift (7:00 PM to 7:00 AM) on 04/12/26 to 04/13/26 and was assigned to the South wing. On 04/15/26 at 1:52 PM, a phone interview was attempted with Staff H, RN, there was no answer and a voicemail was left with contact information. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] with a re-admission on [DATE] with diagnoses that included: Anoxic Brain Damage, Dependence on Respirator [Ventilator], Tracheostomy Status, Gastrostomy Status, Pre-Excitation Syndrome ([NAME]-Parkinson-White Syndrome). The Minimum Data Set (MDS) dated [DATE] revealed Resident #13 is dependent on staff for all Activities of Daily Living (ADLs). During a medication administration observation conducted on 04/15/2026 at 8:18 AM with Staff I, Licensed Practical Nurse (LPN), who stated she has worked at the facility for over 6 years. She was observed dispensing the following medications for Resident #13: Levetiracetam Solution 100 MG/ML, Give 15 ml via G-Tube two times a day for seizures 15 ml= 1500 mg. Multivitamins/Minerals Adult Oral Liquid, Give 15 ml via G-Tube one time a day for Supplement. Vitamin C Oral Tablet (Ascorbic Acid), Give 500 mg via G-Tube one time a day for wound healing Use 250mg tablet, give 2 tablets = 500mg. Enoxaparin Sodium Injection Solution Prefilled Syringe 80 MG/0.8ML, Inject 80 mg subcutaneously one time a day for Deep Vein Thrombosis (DVT) Prevention, please alternate site of injections. Pro-Stat 64 Oral Liquid (Amino Acids Protein Hydrolysate), Give 30 ml via G-Tube two times a day for Supplement. On 04/13/26 at 11:00 AM, Resident #13's physician's orders and Medical Administration Record (MAR) were reviewed for reconcile of ordered medications. All above medications were administered in a timely manner. However, according to the MAR, Metoprolol Tartrate 50 mg tablet related to Pre-Excitation Syndrome, scheduled for 8:00 AM and 8:00 PM, was also administered and initialed by the nurse. Metoprolol Tartrate 50 mg was not observed as administered by the surveyor during the medication administration observation. Review of Resident #13's Medication Administration Audit Report (time stamp) for 04/15/26 revealed the above medications were documented as administered at 8:52 AM. Metoprolol Tartrate 50 mg was also documented as administered at 8:52 AM. During an interview conducted on 04/15/26 at 1:17 PM with Staff I, LPN, who stated when performing medication administration, the nurse checks the physician's orders, makes sure they have the right patient and scheduled time, does hand washing and administers the medications. Staff I then stated she returns to the medication cart and documents the medications as administered. She stated that she did click the Metoprolol 50 mg by mistake, however remembered later and went back and administered the medication to Resident #13. Staff I acknowledged that the medication was given late. Review of the facility's policy titled, Charting and Documentation with a revised date of 08/2025 included in part the following: All services provided to the resident or any changes in the resident's medical or mental condition shall be documented in the resident's medical record. All observations, medications administered, services performed, etc., must be documented in the resident's clinical records.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to implement wound care orders in a timely manner, affecting the daily treatment of a pressure wound for 1 of 1 resident reviewed for facility acquired wounds (Resident #13). The findings included: Review of the facility's policy titled, Wound Treatment Guidelines, dated 01/2025, included the following: Wound Treatment Guidelines: A medical staff approved wound treatment guideline will be used care for patients with current practice utilizing moist wound healing techniques. Procedure:4. The [NAME] wound treatment guidelines may be used to determine or guide a treatment plan.5. Upon receipt of physician's orders, the clinician will implement the treatment/therapy. During the initial tour of the facility conducted on 04/13/26 at 9:15 AM, observed Resident #13 was observed in bed. Resident #13 has contractures of the upper extremity and right had was noted to be completely contracted inward, knuckles laying flat on the bed sheets. Further observation revealed Resident #13's right hand knuckles were covered with a soiled dressing, which was not dated or initialed. Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] with a re-admission on [DATE] with diagnoses that included: Anoxic Brain Damage, Dependence on Respirator [Ventilator], Tracheostomy Status, Gastrostomy Status. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 is dependent on staff for all Activities of Daily Living (ADLs).Record review of Resident #13's electronic chart revealed the resident did not have a care plan or interventions for pressure wound injuries. Review of Resident #13's [NAME] Wound Physicians' report revealed the resident was seen on 03/23/26 and was diagnosed with unstageable Deep Tissue Injury (DTI) of the right, second finger (site 14) with intact skin; treatment plan to apply skin prep (liquid-applied protective film barrier) once daily and as needed for 30 days. Further review of the report revealed that Resident #13's plan of care was discussed with the nursing staff member.On 03/30/26, Resident #13 was followed up by [NAME] wound physician for the wound on the right hand, site 14, which at this time, the physician staged the wound as 3 (full thickness loss of skin) and changed the treatment plan with primary dressing: Alginate calcium to apply once daily and as needed: if saturated, soiled, or dislodged, for 30 days. Second dressing: Gauze Island with border to apply once daily and as needed for 30 days. Further review of the report revealed that Resident #13's plan of care was discussed with the nursing staff member. On 04/06/26, Resident #13 was followed up by [NAME] wound physician for the wound on the right hand, site 14, treatment plan from 03/30/26 was to continue, and the care was discussed with the nursing staff member. In addition, Resident #13 had a skin tear wound of the right hand (site 15) with treatment plan with foam silicone border and faced apply three times per week and as needed.Review of the Physician's Orders showed that Resident #13 had an order dated 04/13/26 with an active date for 04/14/26, Apply to Right knuckle topically one time a day for Wound, apply once a day then cover with border dressing. Further review of discontinued/completed orders revealed there were no other wound care treatments in place prior to 04/13/26. During wound care observation conducted on 04/15/26 at 12:07 PM with Staff I, Licensed Practical Nurse (LPN) for Resident #13, who stated she works the 7:00 AM to 7:00 PM shift. She stated she is not sure when wound care is scheduled, but she does not usually do wound care for Resident #13. During an interview conducted on 04/15/26 at 4:05 PM with Staff D, Registered Nurse (RN), who stated she has worked at the facility for 4 months. She stated the Director of Nursing (DON) is usually the one that enters physician's orders. If there's admission or re-admission, the floor nurse will enter orders, but for the most part is the DON who enters physician's orders.On 04/16/26 at 5:18 PM an interview was conducted with the DON. She stated that she or the floor nurses enter physician's orders into the electronic record. She stated that the [NAME] wound doctor is new to the facility, maybe started about a month ago. She stated the wound doctor usually does rounds on her own and if there's any changes she would communicate it to the floor nurse. The DON explained that the [NAME] doctor has (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	access to the computer system and uploads her notes; at this time, she and the nurses can view/read the wound doctor's report. She was asked about Resident #13's wound care orders and why there were no wound care orders prior to 04/14/26. She stated that wound care orders were verbally communicated to the nurses. She was asked how the nurses would know which shift was responsible for the wound care or if it was done; she stated it is a fair question and acknowledged that there was no order in place prior to 04/14/26.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow physician's orders in a timely manner for application of bilateral orthotic boots for 1 of 2 sampled residents reviewed for range of motion, Resident #20. The findings included:Review of the facility's policy titled, Patient Orthoses, dated 12/24, included the following: Orthoses will be ordered and applied to clients to prevent and/or alleviate contractures, to promote optimal alignment, and to increase functional participation in activities. Procedure:6. Documentation to be placed in the physical management plan should include: a) Name of clientb) Date orthotic is issuedc) Wearing scheduled) Picture/illustratione) Specific instruction for orthotic application. Record review revealed Resident #20 was admitted to the facility on [DATE] with diagnoses that included: Quadriplegia, C1-C4 Complete; Tracheostomy Status; Dependence on Respirator [Ventilator] Status; Gastrostomy Status; Acute and Chronic Respiratory Failure. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #20 has bilateral impairment of upper and lower extremities. The MDS documented that Resident #20 was dependent upon staff for all Activities of Daily Living (ADLs).Review of the physician's orders showed Resident #20 had an order dated 03/19/26 for MultiPodus boots (an orthotic device designed to treat, prevent, and correct foot drop, plantar flexion contractures, and heel pressure ulcers). The boots are to be worn in bed, 8 hours on, 4 hours off, continuously for 24 hours.During the initial tour of the facility on 04/13/26 at 9:10 AM, Resident #20 was observed in bed watching cartoons on his iPad, the head of the bed was elevated and he was not wearing the orthotic boots. Further observation revealed the boots were at the foot of the bed. At 12:34 PM, during dining observation, again observations noted the boots were at the foot of the bed and not on the resident.On 04/14/26 at 9:24 AM, on the South wing, Resident #20 was observed in bed, watching a show on his iPad and not wearing the boots. Further observation revealed the boots were at the foot of the bed. At 3:20 PM, Resident #20 was observed in bed and not wearing boots.On 04/15/26 at 8:30 AM, during a medication administration observation of Resident #20's roommate revealed Resident #20 was in bed with his feet uncovered and not wearing the boots, which were observed at the foot of the bed. Further observation revealed Resident #20 has bilateral foot drop. At 2:30 PM, Resident #20 was observed in bed and again not wearing boots.On 04/16/26 at 10:18 AM, Resident #20 was observed in bed and was wearing orthotic boots. At 7:15 PM, Resident #20 was observed in bed and still wearing orthotic boots (over the 8 hours timeframe). During an interview conducted on 04/16/26 at 10:12 AM with Staff J, Certified Nursing Assistant (CNA), she stated she has worked at the facility for 2 years. She stated that therapy puts on the boots for Resident #20. She stated she does not take them off; therapy also does that. She stated it is the responsibility of the therapist.During an interview conducted on 04/16/26 at 10:21 AM with Staff K, Physical Therapist (PT), she stated she works at the facility 3 days per week. She stated Resident #20 has orders for ankle splints (orthotic boots) and the hand splints that will be delivered soon. There is a PT aide that comes in and checks on the residents, and if they are not wearing the splints, the PT aide assist in putting them on. Staff J stated she enters the order for the splints however it is the responsibility of the CNAs to put them on after providing daily care. She stated PT educates the CNAs on how to put the splints on. The PT aide called out today, but nursing is responsible to follow and make sure splints are worn. Staff J confirmed that this morning Resident #20 was not wearing the orthotic boots and the Occupational Therapist (OT) assisted her to put on the orthotic boots on the resident.During an interview conducted on 04/16/26 at 10:29 AM with Staff L, Registered Nurse (RN), she stated she has worked at the facility for almost two years. She stated that therapy puts on the splints, however, nursing can do it as well.During an interview conducted on 04/16/26 at 12:04 PM with Staff I, Licensed Practical Nurse (LPN),she stated nursing is responsible to put the boots on Resident #20. She acknowledged that she (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was assigned to Resident #20 yesterday, however, did not see the resident with the boots on. She was asked if the resident has ever refused to wear the boots and if she documents it anywhere. Staff I stated she has not documented any refusal.On 04/16/26 at 1:00 PM, an interview was conducted with the Director of Nursing (DON) who was made aware of the above concerns.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and observation, the facility failed to provide enteral feedings per physicians' orders for 2 of 2 sampled residents, Resident #10 and Resident #2, reviewed for enteral feeding (tube feeding). This has the potential to affect 26 residents who had orders for enteral feedings. The findings included: Review of The American Society for Parenteral and Enteral Nutrition (ASPEN) Safe Practices for Enteral Nutrition Therapy (Journal of Parenteral and Enteral Nutrition, Volume 41, Number 1, January 2017 15-103. DOI: 10.1177/0148607116673053) was conducted. ASPEN recommends the inclusion of critical elements in tube feeding orders. The critical elements include the patient's name, the name of the formula, the delivery site, the administration method and rate, and the volume per feeding or total volume per day. The development of nurse-driven protocols for volume-based feeding was recommended.1. Record review revealed Resident #10 was admitted to the facility on [DATE], with diagnoses that included Unspecified Protein Calorie Malnutrition, Gastritis, and Other Artificial Openings of Gastrointestinal Tract. Review of the physician's order dated 02/19/26 stated to administer a mixture of 280 milliliters of Pediasure 1.0 (calorie/milliliter) plus 30 milliliters of formula every 4 hours (6 times every day). The formula was to be administered via jejunum tube at a rate of 77 milliliters per hour continuously for 24 hours by pump. The physician's order listed: 24-hour total formula: 1680 ml and water 180 ml. The total volume of fluids administered in the 24-hours according to the physician's order was 1860 milliliters (1680 + 180). Resident #10's care plan, initiated 07/23/25, specified that he relied on tube feeding for all nutrition and hydration needs due to dysphagia (swallowing difficulty). The intervention stated to provide the tube feeding as ordered. An observation of Resident #10 was made on 04/15/26 at 10:30 AM. Resident #10 was in bed and receiving the administration of Pediasure 1.0 Calorie formula via pump. Staff C, a Registered Nurse, was present.An interview was conducted with Staff C on 04/15/26 at 10:30 AM. When asked to press the history button on the pump to see how many milliliters of fluids (formula plus water mixture) was administered in the past 72 hours, the digital display showed 4164 milliliters was administered. The total volume in milliliters that should have been administered in 72 hours was 5580 milliliters (1860 milliliters x 3 days). Resident #10 received 74.6% of the volume of the formula plus water mixture that was ordered. Resident #10 received 1416 milliliters (of the formula plus water mixture) less than he was ordered to receive in a 3-day period. Resident #10 received on average a shortage of 472 milliliters per day.An interview with the Registered Dietitian (RD) on 04/15/26 at 4:32 PM revealed that the RD agreed Resident #10 should have received 5580 milliliters of the combined formula plus water mixture in 72 hours.An interview with Staff C on 04/15/26 at 5:27 PM revealed that the pump was turned off several times each day for activities of daily living that included changing the resident's briefs. Other activities, that included bathing, or cuddling with his mother, were additional reasons that the machine was turned off. Staff C said that sometimes a CNA (Certified Nursing Assistant) may have turned off the feeding to provide care. Since the CNA is unable to restart the pump, there may have been delays in turning the pump back on. When asked what the possible consequences were when a resident received too little enteral feeding, Staff C said that the resident could have become dehydrated. 2. Record review revealed Resident #2 was admitted to the facility on [DATE], with diagnoses that included Gastrostomy Status (a surgical opening in stomach for a feeding tube), and Failure to Thrive. One of the physician's orders for enteral feeding was to administer Nutren [NAME] formula at 45 milliliters per hour continuously via jejunum tube, and to administer a water flush at 45 milliliters every 6 hours. Another enteral feeding order was to administer water flush at 45 milliliters every 6 hours. The physician's orders did not include the total volume of formula or the total amount of water to be administered per feeding or per day.An interview was conducted with a Registered Nurse, Staff D, on 04/15/2026 at 2:15 PM. Staff D was asked to press the history button on the pump to reveal the volume of formula and the volume of water flush (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that was administered in the past 72 hours. The amount of formula printed on the digital display said 2364 milliliters. The amount of water flush printed on the digital display was 360 milliliters. The average amount of formula administered in the 24-hour periods of time for the past 3 days was 788 milliliters. Resident #2 received 72.9% of the formula that he was ordered to receive as specified by the physician's order. When Staff D was asked what she thought the reasons were that had contributed to Resident #2 receiving too little formula, Staff D said that there were times that the pump was turned off. She explained that the pump was turned off when they changed Resident #2's diaper. The pump was also turned off for medication administration, and during transfers from his chair to his bed. Staff D said that Resident #2 liked to move around in his crib, and at times he wanted to grab onto the crib's rails. Staff D explained that for these reasons, at times, the pump was disconnected and the feedings were resumed at a later time.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to obtain orders for respiratory care including suctioning and trach care for 2 of 2 sampled residents reviewed for respiratory, Residents #4, and #28. The findings included:According to the website: https://www.ncbi.nlm.nih.gov/books/NBK593189/#:~:text=In%20emergent%20situations%2C%20a%20provide the following in part was included: In emergent situations, a provider order is not necessary for suctioning to maintain a patient's airway. However, routine suctioning does require a provider order. 1. Record review for Resident #4 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on [DATE] with diagnoses that included in part the following: Cerebral Palsy, Dependence on Respirator (Ventilator) Status, Tracheostomy Status, Cleft Palate, Other Apnea of Newborns, and Myotonic Muscular Dystrophy. The Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status was not completed due to the resident is rarely/never understood.Review of the physician's orders for Resident #4 revealed in part the following:An order dated 11/17/22 to change trach monthly and as needed. Trach size # 4.5 Bivona Flex cuffed. Length of 52mm one time a day every 1 month(s) starting on the 1st for 1 day(s) and as needed.An order dated 02/02/25 for Vent settings LTV 1150 Pressure mode Rate of 14 inspiratory pressure 18 above a Peep of 6 for total of 24 Pressure support 18 inspiratory time 0.7 cough assist and CPT every 4 hours.An order dated 11/17/22 to keep gauze under tracheotomy cuff/flange between skin and trach and skin to prevent skin irritation and breakdown two times a day for To prevent skin breakdown to be applied during trach care and as needed and every 12 hours as needed for to prevent skin breakdown.In summary there was no order for suction.Review of the care plan for Resident #4 dated 03/24/21 with a focus on the resident has Tracheostomy related to disease process. The goals were for the resident to have clear and equal breath sounds bilaterally, to have no signs/symptoms of infection, and to have no abnormal drainage around trach site through the review date. The interventions included in part the following: Suction as necessary. 2. Record review for Resident #28 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Obstructive Hydrocephalus, Tracheostomy Status, Presence of Cerebrospinal Fluid Drainage Device and Unspecified Lack of Expected Normal Physiological Development in Childhood.Review of the physician's orders for Resident #28 revealed in part the following:An order dated 02/26/26 to Change trach monthly on first of the month and prn as needed.In summary, there was no order for suction or trach care.Review of the care plan for Resident #28 dated 01/19/26 with a focus on the resident has a tracheostomy due to Respiratory Failure. The goals were to have patent airway to be maintained and to maintain optimal gas exchange. The interventions included in part the following: Change suction canisters and accessories every Monday, Wednesday, and Friday and as needed. Normal Saline lavage and suction as needed for airway clearance. Tracheostomy care with vitamin A&D ointment twice daily and as needed to maintain skin integrity .During an interview conducted on 04/15/26 at 10:30 AM with Staff N, Certified Respiratory Therapist, she was asked about orders for trach care and suctioning for residents with tracheostomy, she said each resident has orders for trach care and for suctioning.During an interview conducted on 04/15/26 at 2:00 PM with the Director of Nursing (DON), she was asked how often trach care was performed. She said it is performed every shift (two 12-hour shifts per day) by the respiratory therapist. She said they document the trach care on the Respiratory Medication Administration Record (RMAR). When asked if each resident has orders for trach care, she said yes.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor for behaviors and side effects for residents receiving psychotropic medications for 3 of 28 sampled residents receiving psychotropic medications, Residents #25, #13, and #5. The finding included:1. Record review revealed Resident #25 was originally admitted to the facility on [DATE] with most recent readmission on [DATE] with diagnoses that included in part the following: Tracheostomy Status, Dependence on Respiratory (Ventilator) Status, and Other Epilepsy and Recurrent Seizures. Review of the Minimum Data Set (MDS) assessment dated [DATE] documented in Section C a Brief Interview of Mental Status was not conducted due to the resident is rarely/never understood. Review of the physician's orders for Resident #25 revealed an order dated 03/23/26 for Diazepam (a psychotropic medication) oral solution 5 MG\/5ML Give 3 ml via J-Tube three times a day. Review of the record for Resident #25 for the month of April 2026, including the Medication Administration Record (MAR), the Treatment Administration Record (TAR) and progress notes, for Resident #25 revealed no monitoring of behaviors or side effects. During an interview conducted on 04/15/26 at 1:15 PM with Staff D, Registered Nurse (RN), she was asked about monitoring of behaviors and side effects for residents who receive psychotropic medications. She stated they monitor all residents for behaviors and side effects. When asked where this is documented, she said it would be on the MAR. TAR or in progress notes. During an interview conducted on 04/16/26 at 9:45 AM with the Consultant Pharmacist who was asked if Clonazepam, Sertraline and Risperdal where psychotropic medications, he said yes. When asked when he does the pharmacy reviews and recommendations and if he ensures the facility is monitoring for behaviors and side effects, he stated the facility monitors all medications for side effects. When asked about monitoring for behaviors, specifically about Resident #25 and the Clonazepam, he said it is not ordered for psych purposes it is ordered for seizures so they would not be required to monitor for behaviors. He acknowledged they are not documenting any monitoring of behaviors for this resident for the Clonazepam. [NAME] asked about Resident #20, who is prescribed Sertraline for depression, the Consultant Pharmacist said from his understanding they do not need to monitor for behaviors because the medication is ordered for the behavior of depression. When asked about monitoring for side effects, he said every drug is monitored for side effects. He said Resident #20 has an order to notify the DON (Director of Nursing) and physician of any changes in the patient's status so that would be the monitoring of side effects. When asked about Resident #5 who is prescribed Risperdal for irritability, he said they should be monitored for behaviors, and this resident has an order to notify the DON and physician of any changes in the patient's status. During an interview conducted on 04/15/26 at 2:00 PM with the Director of Nursing (DON), she was asked if they monitor for behaviors and side effects for resident who receive psychotropic medications. She stated yes and it would only be documented if there were behaviors or side effects that were not their normal behaviors. When asked if the resident had side effects or behaviors that were not normal and the nurse did not document them, how would she know, she said they would not (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know. 2. Record review for Resident #5 revealed the resident was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Congenital Malformation of Heart; Chromosomal Abnormality; Dependence on Respirator [Ventilator] Status; Gastrostomy Status; Epilepsy; and Tracheostomy Status. The Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) score was not conducted due to Resident #13 being rarely/never understood and was on the following psychotropic medications: antipsychotic, antianxiety and anticonvulsant medications. Review of Resident #5's active and resolved care plans on file revealed that care plans for behavioral problems related to self-injurious behavior such as pulling out G-tube extension, pulling out his tracheostomy, and hitting/biting himself. Goals were to have fewer episodes of pulling at tubing, removing trach, or hitting/biting by review date. Interventions included monitoring behavior episodes and attempting to determine underlying causes and document behavior and potential causes.Review of the care plan revealed Resident #5's use of drugs having an altering effect on the mind characterized by problems with cardiac, neuromuscular, gastrointestinal systems as evidence by decline mood/ behavior. Goals were to have no injury related to medication usage/ side effects and show improvement in mood/ behavior. Interventions included, give medication as prescribed and evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drug, monitor Resident #5's interaction with others for appropriateness, and monitor Resident #5's mood state/ behavior. Review of the physician's orders showed that Resident #5 had orders dated 04/14/25 for Diazepam 5 milligram (mg)/5 milliliters (ml) to be given via G-Tube (Gastrostomy tube) every 6 hours related to Epilepsy; and Lamictal 100 mg tablet to be given via G-Tube one time a day related to Epilepsy. In addition, an order for Risperidone 0.25 mg tablet to give 2 tablets via G-Tube two times a day for irritability associated with autism was added on 02/06/26. Further review of physician's orders and the Medication Administration Record (MAR) revealed no orders for monitoring behaviors or side effects of the above medications. On 04/15/26 at 3:45 PM, an observation was conducted of Resident #5, who was in his room and was very active in his crib. Resident #5 was noted pulling on his tracheostomy's string ties and hitting himself on the right side of his abdominal binder which covers the G-tube. 3. Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] with a readmission on [DATE] with diagnoses that included: Anoxic Brain Damage, Dependence on Respirator [Ventilator], Tracheostomy Status, Gastrostomy Status. The Minimum Data Set (MDS) assessment dated [DATE] revealed the Brief Interview for Mental Status (BIMS) score was not conducted due to Resident #13 being rarely/never understood and was on the following medications: antianxiety (psychotropic), anticoagulant and anticonvulsant. Review of the physician's orders showed that Resident #13 had orders for the following medications: Valproic Acid Solution (anticonvulsant/hypnotic) 250 milligrams (mg)/5 milliliters (ml), to be give 1 gram via G-Tube (Gastrostomy) three times a day for Seizures 1 gram = 20 ml, dated 11/09/24; and Levetiracetam Solution (anticonvulsant) 100 mg/ml, to give 15 ml via G-Tube two times a day for seizure 15 ml = 1500 mg, dated 08/25/25. In addition, there was an order dated 11/12/25 for Diazepam (antianxiety) 10 mg tablet to give 10 mg via G-Tube four times a day for Seizure. Further review of physician's orders and the medication administration record (MAR) revealed no orders for (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring behaviors or side effects of the above medications. During several observations between 04/13/26 and 04/16/26, Resident #13 observed with eyes closed and appeared to be sleeping. On 04/16/26, he was observed in bed, and the Activities Director was at the bedside. She was massaging his hands and talking to him; however, he had his eyes closed, no facial expression and again appeared to be sleeping. During an interview conducted on 04/16/26 at 10:29 AM with Staff L, Registered Nurse (RN), she stated she has worked at the facility for almost two years. She stated she's assigned to the South wing (Resident #5 and #13). She stated that she does not have anyone assigned to her that requires monitoring for behaviors or for side effects of medications. During an interview conducted on 04/16/26 at 11:01 AM with Staff I, Licensed Practical Nurse (LPN), she stated there's a binder on the medication cart for behavior monitoring; and there are only two residents in the facility that are monitored for behaviors. She stated they do not monitor side effects of the medications, however, if they see any changes in the resident's behavior, they contact the Director of Nursing (DON) and the provider.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to follow infection control protocol as evidenced by not properly wearing Personal Protection Equipment (PPE) during tracheotomy care for 1 of 2 sampled residents reviewed for tracheotomy, Resident #13; and failed to ensure that it practiced appropriate hand hygiene while dispensing medications for 1 of 6 sampled residents reviewed during medication administration observation, Resident #1. The findings included:1. Record review for Resident #13 revealed the resident was admitted to the facility on [DATE] with a re-admission on [DATE] with diagnoses that included: Anoxic Brain Damage, Dependence on Respirator [Ventilator], Tracheostomy Status, Gastrostomy Status, Sepsis due to Serratia (bacteria), Lobar Pneumonia, Unspecified Organism, and Pulmonary Mycobacterial Infection. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 is dependent on staff for all Activities of Daily Living (ADLs).During an afternoon tour of the facility conducted on 04/13/26 at 3:10 PM, the surveyor entered Resident #13's room and found Staff M, Certified Respiratory Therapist (CRT), was in the room. He was observed standing on the left side of the resident's bed and was tying the strings of the tracheostomy (trach) without wearing gloves or gown. Further observation revealed soiled dressings, trach strings and a pink plastic tray (no gloves were noted) on the foot of the bed on top of the bed linen without any barrier. Staff M noticed the surveyor and stated he was just adjusting the bands and strings of the trach. The surveyor asked Staff M to remove the covers to see Resident #13's hands. Staff M went and got clean gloves and without performing hand hygiene, donned on the gloves. He returned to the bedside and collected all the soiled items at the foot of the bed, discarded them in the garbage including the gloves, and without performing hand hygiene, donned on clean gloves. He returned and placed a towel on the left side of resident's face and removed the covers to see the resident's hands.During an interview conducted on 04/15/26 at 3:53 PM with Staff G, CRT, who stated she has worked at the facility for 5 years. She stated the CRT is responsible for trach care and changes of trach, respiratory treatments, suctioning, assessing, and assisting nursing when needed. She stated as per facility protocol the CRT is to wear Personal Protective Equipment (PPE) during any care, especially suctioning and trach care. Staff M then stated even if you need to adjust the trach or the ties, they are to wear PPE or at least gloves.An interview was conducted on 04/16/26 at 10:40 AM with Staff M, CRT, who stated he has worked at the facility for 5 years. He stated they are to wear PPE for treatments and trach care and especially suctioning. He stated that he had finished suctioning Resident #13 and providing trach care and he had removed his gloves, then he put on his gloves because the surveyor asked to see the resident's hands. Staff M was asked if he thought it was a good idea to provide trach care without gloves and he stated no. He stated he was not sure what happened that day. He acknowledged that he was not wearing gloves. 2. Record review for Resident #1 revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Sepsis, Bronchitis; Lafora Progressive Myoclonus Epilepsy, Intractable, with Status Epilepticus; Convulsions; Generalized Idiopathic Epilepsy and Epileptic Syndromes; Dependence on Respirator [Ventilator] Status; Tracheostomy Status; Gastrostomy Status; and Bacteremia.During a medication administration observation conducted on 04/14/2026 at 9:32 AM with Staff C, Registered Nurse (RN), was observed in front of the medication cart and wearing gloves. She stated Resident #1 gets all his medications via Gastrostomy tube (G-tube). While still wearing gloves, Staff C opened the computer, got medication cups and dispensed the following medications: Centrum-adult liquid; Multivitamins / Minerals Adult Oral Liquid to give 15 milliliters (ml) via G-Tube one time a day for Supplement; Topiramate 200 milligrams (mg) tablet to given via G-Tube two times a day related to Unspecified Convulsions; Valproate Sodium Solution 250 mg/5ml to give 10 ml via G-Tube every 6 hours related to Unspecified Convulsions; Generalized Idiopathic Epilepsy and Epileptic Syndromes; and Zonisamide 100 mg capsule to give 200 mg via G-Tube one time a day related to Unspecified (continued on next page)

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	04/16/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Convulsions; Generalized Idiopathic Epilepsy and Epileptic Syndromes. Staff C was observed wearing gloves while dispensing the first 3 above medications, touching the medication cart drawers and grabbing the medication bingo cards, touching the computer mouse, and crushing the medication using the pill crusher. Then she dispensed the two Zonisamide 100 mg capsules. She stated she must open the capsules. Without removing the gloves or performing hand hygiene, she grabbed one capsule and opened it and dumped the contents into a medication cup; then grabbed the other capsule and while dumping the contents into the same medication cup, one of the capsule's casing fell into the medication cup. At this time, Staff C was observed picking the casing out of medication cup still wearing the same gloves. Throughout the dispensing process, Staff C did not perform hand hygiene or changed her gloves.During an interview conducted on 04/14/26 at 9:50 AM with Staff C, RN, stated she has worked at the facility for 2 years. She was asked if it was protocol to wear gloves while dispensing medications. She stated yes because the medications need to be crushed. She then stated she had to open the capsules (Zonisamide 100 mg) because the resident receives all the medications via G-tube and she needs to wear gloves. Staff C was then asked if she should have changed the gloves prior to opening the capsules and stated, no need, that's why she dispensed the Zonisamide capsules last and then she would remove the gloves before entering the room.During an interview conducted on 04/15/26 at 11:02 AM with the Director of Nursing (DON), she stated she has worked at the facility for over 5 months. She was made aware of the concerns with infection control. She also acknowledged that it is not protocol for the nurse to wear gloves while dispensing the medications unless the medication requires to be touched such as opening a capsule.