STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A011	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Especially Kidz Health & Rehab	2325 S Miller St Shelbyville, IN 46176

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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 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** 30344 Based on observation, interview, and record review, the facility failed to assist a resident with getting out of bed for 1 of 1 resident reviewed for choices and to ensure residents requiring assistance with Activities of Daily Living (ADLs) receive adequate assistance with oral care. (Resident 22, Resident 21 and Resident 85) Findings include: 1. The clinical record for Resident 22 was reviewed on 3/31/25 at 11:45 a.m. Her diagnoses included, but were not limited to, cerebral palsy, profound intellectual disabilities, epilepsy, organic brain syndrome, spastic quadriparesis, and wound infection. The 3/6/25 Significant Change MDS (Minimum Data Set) assessment indicated she was moderately, cognitively impaired. She had unclear speech but was usually understood with difficulty communicating some words or finishing thoughts, but was able, if prompted or given time. She sometimes understood others. Her hearing was adequate. She had upper and lower extremity impairment on both sides. She was dependent on staff for transfers from the bed to a chair. She used a wheelchair and was unable to walk. She also had a stage 4 pressure ulcer. The 3/18/25 hospital discharge notes indicated she had a sacral wound infection after a 2/4/25 surgery involving debridement and skin flap. She was discharged back to the facility on [DATE]. The 3/14/25 hospital progress note indicated Resident 22's mother was at the bedside. The ADL (Activities of Daily Living) care plan, last reviewed 2/25/25, indicated the goal was for her to be provided with the necessary staff assistance to complete her ADLs. An observation and interview were conducted with Resident 22 on 3/31/25 at 11:04 a.m. Resident 22 was lying in bed, awake. She indicated she hadn't gotten out of bed yet today, but was ready to, by nodding her head yes, when asked. An interview was conducted with Resident 22's mother on 3/31/25 at 2:30 p.m. She indicated she wasn't sure when Resident 22 got out of bed at the facility. An observation of Resident 22 lying in bed was made on 4/1/25 at 10:36 a.m. and 4/1/25 at 1:50 p.m. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with CNA (Certified Nurse Aide) 2 on 4/1/25 at 1:51 p.m. He indicated he was assigned to care for Resident 22 today. He did not assist her to get out of bed today, because she was unable to get out of bed right now, due to her sacral wound repair. She was unable to be in her wheelchair. Ever since she returned from her 3/18/25 hospitalization , she had orders to just turn and reposition her in bed. Resident 22's physician's orders did not include an order to remain in bed. An interview was conducted with the DON (Director of Nursing) on 4/1/25 at 3:13 p.m. She reviewed Resident 22's 3/18/25 hospital notes and indicated they referenced her being bedbound, but not that she needed to remain in bed. She got up for bathing and in the evenings sometimes. She was going to make sure all staff who cared for her knew she was able to get out of bed. The DON provided the Care Plan Development and Review policy on 4/2/25 at 12:36 p.m. It indicated, This facility shall then develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment . 51984 2. A record review conducted, on 4/1/25 at 11:12 a.m., indicated Resident 21's diagnoses included, but were not limited to, cerebral palsy and profound intellectual disabilities. A current care plan, initiated on 1/9/25, indicated Resident 21 required staff assistance with oral care with an intervention listed as . 3. Use lip balm as needed to keep lips moist and prevent cracking. A physician order, dated 9/26/22, indicated oral care was to be completed every shift. An observation was conducted of Resident 21 on 3/31/25 at 1:57 p.m. Resident 21 was sitting in the hallway in her wheelchair. She was observed with dry skin on her lips. An observation was conducted of Resident 21 in her room on 4/1/25 at 10:02 a.m. She was observed in her wheelchair and had dry skin on her lips. 3. A record review conducted, on 3/31/25 at 2:28 p.m., indicated Resident 85 diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs, as well as the trunk and face). A current care plan, dated 1/9/25, indicated Resident 85 required staff assistance with oral care with an intervention listed as .3. Use lip balm as needed to keep lips moist and prevent cracking. A physician order, dated 9/28/22, indicated oral care was to be completed every shift. Observations were conducted of Resident 85 on 3/31/25 at 2:28 p.m. and 4/1/25 at 10:01 a.m. Resident 85 was sitting in her wheelchair in her room. She was observed with dry skin on her upper and lower lips. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Licensed Practical Nurse (LPN) 5 on 4/1/25 at 10:20 a.m. She indicated all residents should have house lip balm in their drawers, unless otherwise indicated in the residents' orders. LPN 5 checked Resident 85's drawers for lip balm and did not find any. Then she went to check Resident 21's drawers for lip balm, and she did not find any. LPN 5 went to the storage closet and got lip balm for Resident 85 and Resident 21 and applied it to each of them. LPN 5 indicated Resident 21 and Resident 85's oral care orders included brushing the resident's teeth and applying lip balm three times a day as needed. A policy titled Oral Care, dated 10/14, was proved by the DON on 4/2/25 at 11:44 a.m. The policy indicated . Policy: Nursing personnel is responsible to ensure that oral care is completed at least daily and as indicated for those resident unable to provide their own mouth care. Oral care is inclusive of brushing teeth/dentures. Administering mouthwash, and flossing, as indicated . 3.1-38(a)(3)(C) 3.1-38(b)(6)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 34850 Based on observation, interview and record review, the facility failed to ensure a resident was provided activities for 1 of 1 resident reviewed for activities. (Resident 71) Findings include: The clinical record for Resident 71 was reviewed on 3/31/25 at 2:00 p.m. The diagnoses included, but were not limited to, traumatic brain injury and quadriplegia (partial or complete paralysis of both the arms and legs). An activities care plan, revision date of 1/23/25, indicated Resident 71 may benefit from activities for cognitive, social and sensory stimulation. Activities to include, but not limited to music, sensory stimulation, stories, tv, and massage. TV/Music will be on in room while awake as tolerated . An observation was conducted of Resident 71 in his room on 3/31/25 at 11:15 a.m. The resident was in bed with his eyes open. The resident's television was not turned on nor was any music playing. An interview was conducted with Resident 71's Representative on 3/31/25 at 2:36 p.m. She indicated she visited the resident on Sundays. The resident was observed on those days in bed. She was told by the staff, Sundays are lazy days. An observation was conducted of Resident 71 in his room on 4/1/25 at 11:15 a.m. The resident was observed dressed and in his chair with his eyes open. The resident's television was turned off and there was no music playing. An observation was conducted of Resident 71 in his room on 4/2/25 at 8:46 a.m. The resident was dressed in bed with his eyes open. The resident's television was turned off and there was no music playing. An observation was conducted of Resident 71 in his room on 4/2/25 at 9:57 a.m. The resident was dressed and in his chair with his eyes open. The resident's television was turned off and there was no music playing. An observation was conducted of Resident 71 with Unit Manager (UM) 12 on 4/2/25 at 10:06 a.m. The resident was sitting in his chair with his eyes open. The resident's television was not turned on. UM 12 indicated, at that time, the resident loves his rap music. The television should be on. The resident's response to hearing the statement made about the love of rap music; he began to smile and move/dance in his chair. UM 12, at that time, looked all over the room to locate his remote control to his television without success. She attempted to utilize the remote that belonged to Resident 71's roommate. The roommate's remote was unable to work on Resident 71's television. UM 12 indicated she was going to speak with social services to see if she has an extra remote for him and/or order the resident a new remote. At that time, the therapy department had entered the resident's room to take the resident to attend therapy services. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A restorative nursing tracking log, dated 4/2/25, indicated the resident had spent 20 minutes with therapy. An interview was conducted with the Assistant Executive Director (AED) on 4/2/25 at 1:40 p.m. She indicated Resident 71's Representative would like for the resident at times to have quiet time. An interview was conducted with Resident 71's Representative on 4/2/25 at 1:54 p.m. She indicated Resident 71 enjoyed all types of music. She was fine with the resident having quiet time as well as listening to music at a low volume. The resident's care plan did not indicate the resident preferred to be provided with quiet time. An activities policy was provided by the AED on 4/2/25 at 1:40 p.m. It indicated, Policy: This facility should provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing to support residents in their choice of activities, both facility sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence an interaction in the community. 3.1-33(a)

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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. 52119 Based on observation, interview, and record review, the facility failed to ensure a resident's wheelchair had the necessary head support equipment for 1 of 1 resident reviewed for positioning (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 4/2/25 at 11:00 a.m. The diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy (impaired movements characterized by paralysis of both arms and both legs, with muscle stiffness), neuromuscular scoliosis (irregular curving of the spine), and epilepsy (seizure disorder). A quarterly Minimum Data Set (MDS) assessment, dated 12/23/24, indicated Resident 20 had impairments with his upper and lower extremities. A current care plan titled Adaptive Wheelchair, last reviewed on 3/20/25, noted Resident requires the use of an adaptive wheelchair 2 [secondary] to the inability to maintain proper body positioning and alignment. A current care plan titled Adaptive Wheelchair - Manual, last reviewed on 12/31/24, noted, The following adaptations may include any or all of the following .Standard Headrest, Heads-Up Headrest . On 4/1/25 at 9:19 a.m., Resident 20 was observed sitting in his wheelchair in his room, in front of the television. There was no headrest attached to his wheelchair. The resident kept falling asleep, and his head repeatedly lolled backward and then jerked forward. On 4/1/25 at 9:37 a.m., Resident 20 was still in his wheelchair, which had no headrest attached. His head was still lolling backward and then jerking forward repeatedly. On 4/2/25 at 10:31 a.m., Resident 20 was observed sleeping in his Posey bed (a fully enclosed bed to promote safety and reduce falls). His wheelchair was in his room, and it did not have a headrest attached to it. In an interview on 4/2/25 at 10:38 a.m., Certified Nurse Aide (CNA) 2 indicated the wheelchair with no headrest belonged to Resident 20. There should be a headrest on the wheelchair, but maybe someone took it off to clean it and forgot to put it back on. The Physical Therapist (PT) would know more about what type of headrest the resident needed. In an interview on 4/2/25 at 10:40 a.m., Physical Therapist (PT) 9 indicated a head rest should be on Resident 20's wheelchair, because they were standard on all the wheelchairs there. She was not sure why it was not attached but would look into it. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/2/25 at 10:50 a.m., PT 9 indicated she found Resident 20's wheelchair headrest in his closet and re-attached it. She adjusted it so it was at the proper height for the resident's head. In an interview on 4/2/25 at 1:45 p.m., the Assistant Executive Director indicated they did not have a policy for adaptive equipment. 3.1-42(a)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51984 Based on observation, interview, and record review, the facility failed to ensure unopened food in the freezer was stored properly. This had the potential to affect 24 of 114 residents that receive food from the kitchen. Findings include: The facility kitchen was observed with Dietary Supervisor (DS) 6 on 3/31/25 at 10:15 a.m. During the tour, the walk-in freezer was observed with the following items not closed/secured: One box of tater tots, Two boxes of mixed vegetables, and One box of pork patties, An interview was conducted with DS 6 on 3/31/25 at 10:30 a.m. She indicated the box of tater tots, the mixed vegetables, and the pork patties should have been stored preventing air from reaching the product. A storage guidelines policy was provided by DS 6 on 3/31/25 at 11:00 a.m. It indicated, . Frozen items that are not individually wrapped such as cookie dough, biscuits, vegetables, fruit and meat should be placed in a 2-gallon storage bag or wrapped tightly in plastic wrap prior to returning to original box. All open boxes in the freezer must be resealed to prevent damage from frost. Boxes should never be left gaping open for any reason. A dietary policy and procedure, dated August 2024, was provided by the Assistant Executive Director on 4/2/25 at 11:50 a.m. It indicated, Policy: A proper handling procedure for frozen food safety lessens the risk of acquiring foodborne diseases .6. Freezer burn is caused by air, which contacts the food surface, this does not make the food unsafe, it only diminishes the quality. Freezer burn may appear as grayish brown and leathery dry spots. Do not include said portions by cutting them off before or after cooking the food . 3.1-21(i)(2) 3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 34850 Based on observation, interview, and record review, the facility failed to ensure infection control was maintained by utilizing hand hygiene during medication administration for 4 of 5 residents observed during medication administration. (Residents' 26, 38, 49, and 81) Findings include: 1. An observation was conducted of medication administration with Licensed Practical Nurse (LPN) 5 for Resident 81 on 4/1/25 at 8:40 a.m. LPN 5 prepared the resident's medication at the medication cart. LPN 5 utilized hand sanitizer and donned gloves. After, she touched the medication cart, the computer mouse, the narcotic box, and the medication cards with her gloved hands. During that time, she pulled the medication cards from the medication cart popping the resident's pill medications in her gloved hands and dropping the pill medications in the medication cup. She then crushed the pill medications. At that time, LPN 5 indicated the resident was receiving her pill medications through a gastrostomy tube (g-tube; a tube inserted in stomach to receive liquid food and medications). After, LPN 5 doffed her gloves; picked up a new set of gloves from her medication cart. She then walked into Resident 81's room; donned the pair of gloves and a gown (Personal Protective Equipment/PPE) located on the resident's wall. There was no observation of hand hygiene prior to donning a new set of gloves nor the gown. She then administered the medication through the resident's g-tube. 2. An observation was conducted of LPN 5 administering medications to Resident 49 on 4/1/25 at 9:06 a.m. LPN 5 was observed utilizing hand hygiene and donning a pair of gloves. She then pulled and prepped the resident's medication utilizing the gloved hands. LPN 5 pulled out pill medication cards and popped the pill medications directly in her gloved hands. She then placed the pills in a medication cup. During that time, LPN 5 touched the computer mouse, the keys to the medication cart, the medication cart, the lock on the medication cart, and the medication cards with her gloved hands. She then doffed her gloves; crushed the pill medications and then mixed the crushed pills with a puree mixed fruit. After, she went to the resident in the hallway and pushed the resident to her room. She administered the medications at that time to the resident by mouth in her room. There was no observation of hand hygiene prior to the administration of medications. 3. An observation was conducted of an administration of medications to Resident 26 with Qualified Medication Aide (QMA) 10 on 4/1/25 at 9:28 a.m. QMA 10 prepared the resident's pill medications at the cart. QMA 10 indicated that the resident received medications via a g-tube. She then went to the resident's room, donned gloves and a gown prior to administration. There was no hand hygiene observed prior to donning gloves and a gown. 4. An observation was conducted of an administration of medications to Resident 38 with QMA 5 on 4/1/25 at 9:42 a.m. QMA 5 prepared the resident's medications. After, she went to the resident's room and donned a pair of gloves and a gown prior to administration. She then administered the pill medication via g-tube. There was no hand hygiene observed prior to donning gloves or gown prior to medication administration. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Director of Nursing on 4/1/25 at 1:25 p.m. She indicated the nursing staff should not be donning gloves at the medication cart. She should have changed her gloves and utilized hand hygiene. A hand hygiene policy was provided, on 4/2/25 at 8:55 a.m., by the Assistant Director of Nursing (ADON). It indicated, Purpose: Hand hygiene is the single most important measure for preventing the spread of infection. Policy: This facility shall require personnel use accepted hand hygiene after each direct resident contact for which hand hygiene is indicated .Situations that require hand hygiene include, but are not limited to .Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice) .Before and after entering isolation precaution settings .Before and after handling peripheral vascular catheter and other invasive devices .After removing gloves or aprons . A medication administration policy was provided by the ADON on 4/2/25 at 8:55 a.m. It indicated, .Infection control: 1. Wash hands with soap and water. Prior to beginning med pass .Before and after administering . meds, via feeding tubes .2. use alcohol gel or foam between each resident unless using soap and water. 3. Never touch medications with hands . 3.1-18(b)(1) 3.1-18(l)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 36942 Based on observation and interview, the facility failed to ensure a safe, comfortable, and homelike environment for 4 of 5 residents reviewed for homelike environment. (Residents 17, 30, 111, and 115) Findings include: 1. An observation was conducted of Resident 111's room on 3/31/25 at 10:50 a.m. There was a box fan facing her bed that was observed dusty with the left side of the fan missing a cover and exposing the fan blade. The blinds in Resident 111's room were broken with missing pieces to where spaces were left when the blinds were closed. An observation was conducted of Resident 111's room on 4/1/25 at 12:06 p.m. The box fan still contained dust and had the missing cover that exposed the fan blade. The blinds remained broken with missing pieces. 2. An observation was conducted of Resident 30's room on 3/31/25 at 11:08 a.m. There were broken blinds with missing pieces to where spaces were left when the blinds were closed. An observation was conducted of Resident 30's room on 4/1/25 at 12:06 p.m. The blinds remained broken with missing pieces. 3. An observation was conducted of Resident 115's room on 3/31/25 at 11:13 a.m. There were broken blinds with missing pieces to where spaces were left when the blinds were closed. An observation was conducted of Resident 115's room on 4/1/25 at 12:07 p.m. The blinds remained broken with missing pieces. 4. An observation was conducted of Resident 17's room on 3/31/25 at 11:11 a.m. There was a fall mat folded up and located to the side of the residents' back, while they were lying in bed, filling the space between the side of the bed and the wall. There was a layer of dust on the top of the folded up fall mat. An environmental tour was conducted with the Housekeeping Supervisor and the Maintenance Director on 4/1/25 at 2:50 p.m. Resident 111's room was noted with broken blinds and the box fan containing dust built up along with the missing piece that exposed the fan blade. Resident 30's room was noted with broken blinds. Resident 115's room was noted with broken blinds. Resident 17's room was noted with the fall mat folded up along the side of the bed in between the bed and the wall. The fall mat had a layer of dust at the top. The Maintenance Director indicated he was new to the position, and he reached out to a staff member to see what size blinds were needed in Resident 111, 30, and 115's room to see if they had any spare blinds to replace them with. The Housekeeping Supervisor indicated she was not aware Resident 111 had a box fan in her room. The Housekeeping Supervisor indicated dusting items in the residents' rooms were a part of the daily cleaning. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview conducted with the Nurse Consultant, on 4/1/25 at 3:30 p.m., indicated there was no policy regarding the homelike environment. The facility follows the regulations regarding a homelike environment. 3.1-19(f)(5)