STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555587	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Totally Kids Rehabilitation Hospital - D/P Snf	1720 Mountain View Loma Linda, CA 92354

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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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide a neutral and fair arbitration process and agree to arbitrator and venue. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the arbitration agreements (a private way to settle a legal disagreement outside of a traditional courtroom) provided with the selection of a venue convenient to facility and resident (both parties) for three of three sampled residents (Residents 27, 47, and 51).This failure had the potential to limit Residents' choices and access to a fair arbitration process and impede oversight of dispute resolution outcomes. Findings:1. During a review of Resident 27's admission Record (a document that contains demographic and clinical data) and History and Physical (H&P- a document that contains resident's medical history and a hands-on checkup [physical exam]) , the admission Record and H&P indicated, Resident 27 was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure (long term condition when lungs cannot adequately exchange oxygen and carbon dioxide), deletion of chromosome 1p36 (when a small piece is missing from the tip of the short arm of chromosome 1 [chromosome - a thread like structure that act as a storage unit for genetic information]), and Tetralogy of Fallot (a heart defect involving four structural abnormalities that are present at birth).2. During a review of Resident 47's H&P, the H&P indicated Resident 47 was admitted to the facility on [DATE], with diagnoses which included chronic lung disease (long term lung conditions that obstruct airways, destroy lung tissue, or impair breathing), recurrent pneumonias (multiple, separate episodes of one or both lungs infection), and gross developmental delay (significant delay in two or more developmental areas).3. During a review of Resident 51's admission Record and H&P, the admission Record and H&P indicated, Resident 51 was admitted to the facility on [DATE], with diagnoses which included chronic respiratory failure, cerebral palsy (permanent disorder that affect movement, muscle tone, and posture caused by damage to the developing brain), and spastic quadriplegia (jerky movements of the muscle with loss of function affecting both arms and legs).During a concurrent interview and record review on April 16, 2026, at 9:00 AM, with the Director of Case Management (CM2), Resident 27's arbitration agreement titled, Arbitration of Medical Malpractice Disputes, signed on May 20, 2025, the binding arbitration agreement did not provide for the selection of a venue that is convenient to both parties.A continuous interview and record review with CM2, Resident 47's arbitration agreement titled, Arbitration of Medical Malpractice Disputes, signed on May 7, 2019, the binding arbitration agreement did not provide for the selection of a venue that is convenient to both parties.A continuous interview and record review with CM2, Resident 51's arbitration agreement titled, Arbitration of Medical Malpractice Disputes, signed on December 2, 2025, the binding arbitration agreement does not provide for the selection of a venue that is convenient to both parties.CM2 verified Residents 27, 47, and 51 binding arbitration agreements. CM2 confirmed and stated the binding Arbitration agreements for all three residents did not have information regarding the selection of venues that is convenient to both parties. CM 2 further stated there should have been.During an interview on April16, 2026, at 3:41 PM, with the Administrator (ADMIN), the ADMIN stated the Arbitration agreement form does not provide for the selection of a venue that is convenient to both parties. The ADMIN further stated they don't have a policy and procedure (P&P) for arbitration agreement.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive Minimum Data Set (MDS-a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS]) assessment was completed and submitted to CMS in accordance with the required federal submission timeframe for one of two sampled residents (Resident 23).This failure resulted in inadequate monitoring of progress or decline for Resident 23 and the lack of resident specific information to CMS for payment and quality measure monitoring.Findings:During a review of Resident 23's History and Physical (H&P -contains resident's medical history, physical examination and reason for admission to the facility), dated April 14, 2024, the H&P indicated, Resident 23 was admitted to the facility on [DATE], with diagnoses which included arthrogryposis (a rare condition present at birth characterized by multiple stiff joints and limited movements), and multiple congenital anomalies (structural or functional abnormalities that occur during intrauterine life are present at birth).During an interview on April 15, 2026, at 3:45 PM, with the MDS Coordinator Nurse (MDSC), the MDSC stated it is her duty to complete the residents' MDS assessment. The MDSC further stated that the expectation for comprehensive assessment is that it must be completed within 14 calendar days from residents' admission date.During a concurrent interview and record review on April 15, 2026, at 3:55 PM, with the MDSC, Resident 23's Comprehensive MDS assessment data, dated May 2025, was reviewed. The MDSC stated the comprehensive/admission assessment was due on April 28, 2025, and was not done until May 19, 2025 (21 days late).During an interview on April 15, 2026, at 4:50 PM, with the Chief Nursing Officer (CNO), the CNO stated the expectation for the comprehensive/annual assessment is that it must be completed within 14 calendar days from residents' admission date. During a concurrent interview and record review on April 15, 2026, at 5:00 PM, with the CNO, Resident 23's comprehensive MDS assessment data, dated May 2025, was reviewed. The CNO stated that the comprehensive/admission assessment was due on April 28, 2025, and was not done until May 19, 2025. (21 days late).During a concurrent interview and record review on April 15, 2026, at 5:05 PM, with the CNO, the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Assessments, dated March 2024, was reviewed. The P&P indicated, Comprehensive assessments must be completed within 14 calendar days after patients' admission, on significant change in status and annually. The CNO stated that policy was not followed and should have been because it provides accurate reimbursement for the facility and care planning for the residents.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the quarterly Resident Assessment Instrument/Minimum Data Set (RAI/MDS- a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS] every 3 months or quarterly) was completed in accordance with federal submission timeframes, for one of two residents (Residents 23) when Resident 23's quarterly RAI/MDS assessment was not completed within 92 days following the previous assessment. This failure had the potential to result in a delay in determining the resources necessary to competently care for the residents during day-to-day operations and emergencies for Resident 23. Findings: During a review of Resident 23's History and Physical (H&P -contains resident's medical history, physical examination and reason for admission to the facility), dated April 14, 2024, the H&P indicated, Resident 23 was admitted to the facility on June April 14, 2024, with diagnoses which included arthrogryposis (a rare condition present at birth characterized by multiple stiff joints and limited movements), and multiple congenital anomalies (structural or functional abnormalities that occur during intrauterine life are present at birth). During an interview on April 15, 2026, at 3:40 PM, with the MDS Coordinator Nurse (MDSC), the MDSC stated it is her duty to complete the resident's RAI/MDS. The MDSC further stated that the expectation for the quarterly assessment is that it must be completed within 92 days from the prior quarterly assessment. During a concurrent interview and record review on April 15, 2026, at 3:45 PM, with the MDSC, Resident 23's quarterly MDS assessment data (RAI/MDS), dated [DATE], was reviewed. There was no documented evidence that RAI/MDS was completed in April 2026. The MDSC stated the last quarterly assessment was completed on January 5, 2026 (100 days from previous). The MDSC further stated she has not completed the quarterly assessment that was due on April 7, 2026 (8 days late). During an interview on April 15, 2026, at 4:40 PM, with the Chief Nursing Officer (CNO), the CNO stated the expectation for the quarterly assessment is that it must be completed within 92 days from the prior quarterly assessment. During a concurrent interview and record review on April 15, 2026, at 4:45 PM with the CNO, Resident 23's quarterly MDS assessment data, dated April 2026, was reviewed. There was no documented evidence that RAI/MDS was completed in April 2026. The CNO stated the last quarterly assessment was completed on January 5, 2026 (100 days from previous). The CNO further stated MDS quarterly assessment was not completed that was due on April 7, 2026 (8 days late). During a concurrent interview and record review on April 15, 2026, at 4:55 PM, with the CNO, the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Assessments, dated March 2024, was reviewed. The P&P indicated, Quarterly review assessments (non-comprehensive) must be completed at least 92 days following the previous assessment of any type. The CNO stated that policy was not followed and should have been because it provides accurate reimbursement for the facility and care planning for the residents.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS-a facility assessment and care planning process used by nursing home staff as required by the Centers of Medicare and Medicaid Services [CMS]) assessments were accurately coded to reflect the residents' status, care, and services in active diagnoses under Section I for four (4) of 20 residents (Residents 1,19, 20, and 23).This failure had the potential to cause inaccuracy in identifying Resident 1, 19, 20, and 23's care and support needs.Findings: 1. During a review of Resident 1's admission Record (a document that contains demographic and clinical data) and History and Physical (H&P- a document that contains resident's medical history and a hands-on checkup [physical exam]), the admission Record and H&P indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included traumatic brain injury (disruption of normal brain function caused by an outside force), left foot fracture (broken bone) and right big toe fracture. During a concurrent interview and record review on April 13, 2026, at 3:56 PM, with Case Manager Nurse (CM1), Resident 1's MDS Quarterly Assessment (an assessment for a resident that must be completed every 92 days following the previous assessment), dated March 3, 2026, was reviewed. The MDS Quarterly Assessment under Section I titled Active Diagnoses. Infections. 12400. Viral Hepatitis (e.g., Hepatitis A, B, C, D, and E- liver infection caused by different viruses) was checked which indicated that Resident 1 had viral hepatitis. CM1 stated the Viral Hepatitis was checked by mistake since Resident 1 does not have Viral Hepatitis. CM1 further stated the MDS was coded incorrectly. During a concurrent interview and record review on April 16, 2026, at 2:15 PM, with CM1, Resident 1's MDS Quarterly Assessment, dated March 3, 2026, was reviewed. The MDS Quarterly Assessment under section I title Active Diagnoses. Neurological [affecting brain and nervous system] . 15400. Seizure Disorder or Epilepsy (a sudden uncontrolled episode of abnormal electrical activity in the brain, often causing involuntary, rapid, and uncontrollable shaking or spasming of the body, staring spells, or loss of consciousness) was left blank which indicated that Resident 1 did not have a seizure disorder. CM 1 verified and stated the seizure was not documented correctly since Resident 1 had seizure disorder. 2. During a review of Resident 19's admission Record and H&P, the admission Record and H&P indicated, Resident 19 was admitted to the facility on [DATE], with diagnoses which included anoxic brain injury (serious, often permanent condition caused from complete lack of oxygen to the brain, leading to brain cell death), spastic quadriplegia (jerky movements of the muscle with loss of function affecting both arms and legs) and ventilator dependent (a person's body cannot breath enough on its own to stay alive, so they must rely on a machine (a ventilator) to do the work of breathing for them). During a concurrent interview and record review on April 14, 2026, at 4:28 PM, with the MDS coordinator (MDSC), Resident 19's MDS Annual Assessment (an assessment for a resident that must be completed every 366 days following the previous assessment), dated March 20, 2026, was reviewed. The MDS Annual Assessment under Section I titled Active Diagnoses. Genitourinary (the body's reproductive and urinary organs) . 1550. Neurogenic bladder (loss of bladder function caused by nerve damage from the brain) was left blank which indicated that Resident 19 not having an issue with neurogenic bladder. The MDSC verified and stated the MDS was coded incorrectly and Resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	19 had problem with her bladder. 3. During a review of Resident 20's admission Record and H&P, the admission Record and H&P indicated, Resident 20 was admitted to the facility on [DATE], with diagnoses which included premature infant (born before 37 completed weeks of pregnancy), chronic lung disease (long term lung conditions that obstruct airways, destroy lung tissue, or impair breathing) and seizure. During a concurrent interview and record review on April 16, 2026, at 11:34 AM, with the Director Case Management (CM2), Resident 20's MDS Annual Assessment, dated February 14, 2026, was reviewed. The MDS Annual Assessment under Section I titled Active Diagnoses. Neurological. 15400. Seizure Disorder or Epilepsy was left blank which indicated that Resident 20 did not have a seizure disorder. CM2 verified and stated the seizure was not documented correctly since Resident 20 had seizures. 4. During a review of Resident 23's History and Physical, dated December 12, 2025, the History and Physical indicated Resident 23 was admitted to the facility on [DATE], with diagnoses which included arthrogryposis (characterized by multiple joint stiffness present at birth), chronic lung disease (long-term lung damage that makes breathing on a person's own difficult or impossible, requiring a long-term breathing tube) with tracheostomy (a breathing tube placed directly into a person's windpipe to receive oxygen by a machine), and focal seizures. During a concurrent interview and record review on April 16, 2026, at 12:00 PM, with the CM2, Resident 23's MDS Quarterly Assessment under Section I titled, Active diagnoses (Section I5400 Seizure Disorder or Epilepsy), dated January 21, 2026, was reviewed. The MDS Quarterly Assessment under Section I titled, Active Diagnoses (Section I5400 Seizure Disorder or Epilepsy), was left blank. The CM2 stated the MDS coordinator did not accurately complete Resident 23's MDS Quarterly Assessment-Section I since Active Diagnoses should not be blank. During a concurrent interview and record review on April 16, 2026, at 4:25 PM, with the Chief Nursing Officer (CNO), the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Assessments, dated February 6, 2024, was reviewed. The P&P indicated, .Within 14 days after the resident's assessment has been completed, the MDS coordinator or designee must electronically transmit encoded, accurate, and complete MDS data to the QIES ASAP system ([Quality Improvement and Evaluation System - Assessment Submission and Processing] is a secure, web-based system used by healthcare providers to send required patient data to the Centers for Medicare & Medicaid Services). Each individual who completes a portion of assessment must sign and certify the accuracy of that portion of the assessment. The CNO stated the policy was not followed and further stated the quarterly MDS was incorrectly coded.

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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 (an individualized plan that includes residents' health problems, preferences and goals) to meet the needs for one of three sampled residents (Resident 46) when Resident 46 was diagnosed and prescribed medication for new on-set seizures (uncontrolled changes in behaviors and movement) and Resident 46's care plan did not reflect this diagnosis. This failure had the potential for safety measures not to be in place, inadequate monitoring, and poor coordination of care which could lead to physical injury and rehospitalization.Findings: During a review of Resident 46's History and Physical (H&P-medical document that provide brief physical exam), dated August 26, 2024, the H&P indicated, Resident 46 was admitted to the facility December 7, 2022, with diagnoses including cerebral palsy (a disorder caused by abnormal brain development or damage to the brain before, during, or shortly after birth that affects muscle control, balance, and posture) and chronic respiratory failure (a condition that lung cannot provide enough oxygen to body). During a review of Resident 46's Discharge Summary, dated January 15, 2026, the Discharge Summary indicated Resident 46 was hospitalized [DATE], through January 15, 2026, with an admitting diagnosis of new on-set seizure. During a review of Resident 46's Neurology [special medical dealing with brain and nervous system] Consult, dated January 22, 2026, indicated, .Recurrent tonic seizures [one type of seizure] . During a review of Resident 46's LTC [Long Term Care] Physician Order Review/Renewal, dated April 15, 2026, the LTC Physician Order Review/Renewal indicated, Resident 46 was prescribed Keppra (medication used to treat patient with seizures) 750 milligrams (mg- unit of measure) twice daily for seizure management and clonazepam (medication used to treat seizures) 0.25 mg once daily for seizures. During a concurrent interview and record review on April 16, 2026, at 3:00 PM, with Case Manager 1 (CM 1), Resident 46's Long Term Care Plan (LTCP), dated April 16, 2026, was reviewed. The LTCP indicated Resident 46's care plan for seizures was initiated today April 16, 2026. CM 1 stated, Resident 46's LTCP for seizure was started today. CM 1 stated that an LTCP should have been put into place upon her return from the hospital on January 15, 2026, but there was no documented evidence of a seizure care plan in Resident 46's electronic chart. CM 1 stated, a LTCP needs to be individualized to each resident and communicate specific resident needs to ensure consistent resident observation and resident care between staff. CM 1 further stated, there should have been an LTCP for Resident 46's new seizure diagnosis. During a concurrent interview and record review on April 16, 2026, at 4:50 PM, with the Chief Nursing Officer (CNO) the facility's policy and procedure (P&P) titled, Interdisciplinary Team Care Assessments, dated December 16, 2024, was reviewed. The P&P indicated, .IDT assessment: Development and implementation of the plan of care begins on completion of assessments. The assessment should include consideration of current medication, psychosocial, environmental, self-care, educational, and discharge planning factors.IDT care plans. Interdisciplinary team conference will be held for each patient on a quarterly basis and more often if needed. Care plans will also be reviewed when indicated by changes in the patient's condition. The CNO stated, when a patient has a new diagnosis, like new on-set seizures, it is expected that staff initiate a care plan related to the diagnosis and new medication immediately.

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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 observation, interview, and record review, the facility failed to provide respiratory and tracheostomy (a surgically created hole in the front of the neck leading directly into the windpipe to help a patient breathe) care consistent with the facilities policy and procedure (P&P) for two of three sampled patients (Patients 14 and 46) when suction canisters (a disposable container that attaches to a suction machine to safely collect bodily fluids) and suction tubing (a hollow plastic tube connected to suction used to remove fluids, mucus, or blood from a patient's body) were not changed weekly and were available for continued patient use. These failures resulted in contaminated and expired supplies being used to suction the airway on immune-compromised (weakened ability to fight infection and disease) patients and had the potential to cause life threatening infection and poor suction potentially causing the obstruction (clogging) of patient airway.Findings: 1. During a review of Patient 14's History & Physical (H&P - document containing a patient's medical history, physical exam and treatment plan), dated [DATE], the H&P indicated Patient 14 was admitted to the facility on [DATE], with diagnoses including acardi syndrome (a rare genetic disorder that affects the brain and causes severe spasms, distinct eye abnormalities, and moderate-to-severe developmental delays), and respiratory failure (a condition where patient is unable to breath on their own) with tracheostomy and ventilator dependence (a patient relies on a machine to move air in and out of their lungs). During a concurrent observation and interview on [DATE], at 2:55 PM, at Patient 14's bedside, with Respiratory Therapist 1 (RT 1), Patient 14's suction canister and suction tubing were dated [DATE], and contained 500 milliliters (ml - unit of measure) of light greenish liquid. RT 1 confirmed and verified the suction canister and suction tubing were dated [DATE] (13 days from last change). RT 1 stated that the suction canister should be changed at least every seven days. RT 1 stated, the suction canister and suction can be changed more frequently if the items become gunky or dirty to ensure the suction devices are working appropriately and to prevent infection. RT 1 stated that Certified Nurse Assistant (CNA) was responsible for changing the suction canisters and tubing every Sunday or Monday NOC shift (6:00 PM to 6:00 AM), but RT and Registered Nurse (RN) can also change the equipment any time as needed. 2. During a review of Patient 46's H&P, dated [DATE], the H&P indicated, Patient 46 was admitted to the facility on [DATE], with diagnoses including cerebral palsy (a disorder caused by abnormal brain development or damage to the brain before, during, or shortly after birth that affects muscle control, balance, and posture) and chronic respiratory failure with tracheostomy and ventilator dependence. During a concurrent observation and interview on [DATE], at 2:58 PM, at Patient 46's bedside, with RT 1, Patient 46's suction canister and suction tubing were dated [DATE], and contained 750 ml of cloudy green liquid with brownish foam to top and sediment (thick, solid material) on the bottom in the suction canister. RT 1 confirmed and verified the suction canister and suction tubing were dated [DATE] (9 days from last change). RT 1 stated that the suction canister and tubing should be changed at least every 7 days. RT 1 stated, the suction canister and suction can be changed more frequently if the items become gunky or dirty to ensure the suction devices are working appropriately and to prevent infection. RT 1 stated that CNA was responsible for changing the suction canisters and tubing every Sunday or Monday NOC shift, but RT and RN can also change the equipment any time needed. During a concurrent interview and record review on [DATE], at 2:20 PM, with the Chief Nursing Officer (CNO), the facility's P&P tiled, Disposable Equipment, dated [DATE], was reviewed. The P&P indicated, .Disposable equipment will be replaced according to established facility guidelines.The following equipment will be maintained as outlined in the table below and PRN (as needed). Equipment will be labeled with date put in service .Equipment: Suction Tubing, Frequency: weekly, Designated Staff: Nursing/Respiratory. Equipment: Suction Canisters, Frequency: weekly, Designated Staff: Nursing/Respiratory. The CNO stated, it is expected that staff follow the facility's P&P and change the suction canister and suction tubing weekly and more often if (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the devices become soiled or when the canister is full. During a review of the facility's document title, Job Description: Registered Nurse (JD), dated [DATE], the JD indicated, .C. Medical Equipment and Point of Care Testing: Manages, operates, inspects and tests nursing equipment to ensure that it is functioning safely and efficiently prior to use and removes nonfunctioning equipment from use according to hospital policy. During a review of the facility's document titled, Job Description: Respiratory Therapist (JD), dated [DATE], the JD indicated .B. Medication and Treatment Safety.Performs routine respiratory care procedures as appropriate for clinical patient care areas according to hospital policy and protocols.C. Medical Equipment and Point of Care Testing: Sets-up and monitors mechanical ventilators and the associated critical care duties required for such treatment, such as airway management and tracheal suctioning.Manages, operates, inspects and tests respiratory therapy equipment to ensure that it is functioning safely and efficiently.

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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	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff followed safe infection control practices when one Licensed Vocational Nurse (LVN 3) did not perform appropriate hand hygiene (cleaning hands with soap and water or sanitizer to remove germs and prevent sickness) practices during wound care for one of one sampled resident (Resident 6). This failure had the potential to result in cross contamination (the transfer of harmful bacteria) and cause a preventable infection for (Resident 6). Findings: During a review of Resident 6's History and Physical (a foundational medical document created by a clinician to understand a patient's health, diagnose issues, and create a care plan), dated June 5, 2024, the History and Physical indicated Resident 6 was admitted to the facility on [DATE], with diagnoses that included quadriplegic (not being able to move both arms and legs), cerebral palsy (a group of permanent movement disorders that appear in early childhood, caused by abnormal brain development or damage to the developing brain. It can affect muscle tone, posture, and motor skills), and erosive right neck wound (a break in the skin or damage to body tissue from long-term pressure). During a review of Resident 6's Medical Doctor (MD) orders, dated March 2, 2026, the MD orders indicated non-pressure ulcer (damage to the skin and tissue caused by constant pressure, friction, or shearing that cuts off blood flow), right neck wound, neck, right, daily, follow instructions-cleanse wound with Normal saline [sterile water and sodium chloride used for cleansing wounds]. Pat dry. Apply skin prep [cleaning and protecting the healthy skin around a wound]. Collagen sheet and Calcium alginate to wound bed (high-tech dressing method designed to speed healing over wound). Cover with Mepilex dressing [a soft, cushioned foam dressing used to treat draining wounds by absorbing fluid while keeping the wound moist for faster healing]. During an observation April 16, 2026, at 8:35 AM, in Resident 6's room, Resident 6 was slightly upright, and head was turned to the left. LVN 3 performed hand hygiene, placed sterile gloves on, and removed Resident 6's old dressing on his right neck area. LVN 3 cleaned the right neck area with sterile (free from living germs, bacteria, or microorganisms) normal saline and gauze (thin, loosely woven, breathable cotton cloth used primarily in medicine to cover wounds, absorb fluids, and secure dressings). Patted wound dry with sterile gauze. LVN 3 then proceeded to apply skin prep to wound. LVN 3 placed collagen and calcium alginate sheet and the new dry dressing without performing hand hygiene and changing her gloves. During an interview on April 16, 2026, at 8:50 AM, with LVN 3, LVN3 acknowledged she did not change her gloves after she removed the old dressing and before she cleansed the wound and applied the new dressing. During a concurrent interview and record review on April 16, 2026, at 2:57 PM, with the Director of Staff Education (DSE), the In-Service training titled, Dressing changes, undated, was reviewed. The Dressing changes indicated, .Use clean gloves, remove soiled dressing first. Discard the old dressing in proper receptacle. Perform hand hygiene again (gel [used to kill viruses, bacteria, and other microorganisms on the hands] is ok), don (put on) sterile gloves. Clean wound as ordered. Apply dressing as ordered. Perform hand hygiene . The DSE stated, The expectation is to wash hands if visibly soiled or perform hand hygiene with sanitizer after old dressing is removed and before cleansing the wound and applying the new dressing. During a concurrent interview and record review on April 16, 2026, at 3:32 PM, with the Chief Nursing Officer (CNO), the facility's policy and procedure (P&P) titled, Hand hygiene: Infection Control, dated October 16, 2025, was reviewed. The P&P indicated, .Decontaminate [clean] hands after contact with body fluids or excretions, mucous membranes, non-intact skin, and wound dressings if hands are not visibly soiled. The CNO stated the policy was not followed.