STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106018	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glades Health Care Center	230 South Barfield Highway Pahokee, FL 33476

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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 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** 39167 Based on observation, interview and record review, the facility failed to ensure of accurate Minimum Data Set (MDS) assessments for 3 of 3 sampled residents (Resident #33, #15, and #8), specifically a resident with hearing loss, this involved Resident #33; a resident with limited range of motion, this involved Resident #15; and a resident for medication usage, this involved Resident #8. The findings included: 1) Clinical record review revealed that Resident #15 was admitted to the facility on [DATE] with diagnosis that included: Dementia. Review of the quarterly MDS assessment, reference date 10/08/24, indicated Resident #15 was rarely/never understood. No moods or behaviors were recorded in this MDS. Under section GG for functional abilities and goal. It was documented Resident #15 had no impairment in his upper extremity (shoulder, elbow, wrist, and hand). Review of Therapy evaluation/summary dated 04/10/24 revealed Resident #15's proper hand function and skin integrity were impacted by the need for a right hand splint. Review of restorative care plans dated 04/11/24 revealed Resident #15 needed contracture Passive Range of Motion exercises to both upper extremities and splinting 3 times per week until further orders, for diagnosis of right sided weakness. Interventions included: application of right-hand splint 2 to 4 hours. Review of progress notes dated 12/03/24 recorded Resident #15 had right sided weakness. On 12/02/24 at 9:40 AM, an observation was conducted of Resident #15, whereas he was noted lying in bed, his right hand was tightly closed, contracture noted and no splint in place. On 12/02/24 at 1:15 PM Resident #15 was observed in his room lying in a recliner chair, with his right hand tightly closed, contracture noted, and no splint in place. On 12/05/24 at 9:33 AM, an interview with the MDS Coordinator and a side-by-side review of Resident #15's record was also conducted. She agreed the MDS coded no impairment in the resident's upper extremities. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Clinical record review revealed Resident #33 was admitted to the facility on [DATE] with a diagnosis that included: Hypertension (high blood pressure). The quarterly MDS assessment with a reference date of 09/04/24, recorded a Brief Interview for Mental Status score of 02, which indicated Resident #33 was severely cognitively impaired. Further review of the MDS under section B for hearing, speech, and vision, it was recorded Resident #33 had adequate hearing (no difficulty in normal conversation, social interaction, and listening to TV). Review of the care plans, which was revised on 09/10/24, recorded Resident #33 had potential for impaired communication, activity involvement related to hearing loss. Review of progress notes dated 11/11/24 evidenced Resident #33 had potential for impaired communication and activity involvement related to hearing loss. On 12/02/24 at 10:26 AM, Resident #33 was noted lying in bed. When the Surveyor attempted to talk to the resident, he did not answer. His family member, who was near by the room, came over and voiced Resident #33 had severe hearing loss, and he could not hear. On 12/05/24 at 9:42 AM, an interview with the MDS Coordinator and a side-by-side review of Resident #33's MDS was conducted. She agreed the MDS coded no impairment for the hearing. On 12/05/24 at 10:00 AM, another interview was conducted with Resident #33's family member, she revealed Resident #33 used to have two hearing aids, but he threw them away. She further stated right now he does not have any hearing aids, and a family member was planning on getting him new hearing aids. 25404 3) Record review revealed Resident #8 was admitted to the facility on [DATE]. Review of the current orders documented as of 11/09/23 Resident #8 had been receiving the anti-platelet medication Clopidogrel (Plavix) 75 mg daily related to a history of a stroke. Review of the current Minimum Data Set (MDS) assessment dated [DATE] lacked the documented use of any anti-platelet medication. Review of the corresponding Medication Administration Record (MAR) for October 2024 confirmed the administration of the anit-platelet medication to Resident #8. During a side-by-side review of the record and interview on 10/03/24 at approximately 3:00 PM, when asked if anti-platelet medications were coded on the MDS assessment, Staff C, Registered Nurse (RN)/MDS Coordinator stated they were. When asked specifically about the anti-platelet medication for Resident #8, Staff C agreed with the failure to code the medication on the current MDS assessment.

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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** 39026 Based on interview and record review, the facility failed to develop a care plan for 2 of 17 sampled residents (Resident #58 related to an actual fall and Resident #17 for use of bed rails). The findings included: 1) Resident #58 was admitted to the facility on [DATE] with diagnoses that included Falls, General weakness, Hypertension, and Rhabdomylosis (a breakdown of skeletal muscle). Record review revealed Resident #58 had a Brief Interview for Mental Status (BIMS) score of 5 on the annual Minimum Data Set (MDS) assessment dated [DATE]. This indicated the resident had severe cognitive impairment. Further record review revealed on 10/05/24, the resident sustained a fall when he was walking to the bathroom, felt dizzy and fell on his side. A review of the resident's care plans revealed a care plan with a start date of 01/09/24 for potential for significant injury related to fall (edited 10/07/24). Approaches included: redirect prn (as needed) (created on 10/07/24) and keep call light and personal items within his reach (edited 10/07/24). Existing approaches included, remind to observe safety at all times (created on 07/08/24) and anticipate and meet his needs (created 01/09/24). On 10/29/24 the resident sustained another fall from the left side of the bed at 5:49 AM. He was found in the right lateral position, with bilateral upper extremities extended slightly forward per record review. A progress note written by the Director of Nursing (DON) dated 10/29/24 revealed the DON was called to room by nurse, resident c/o (complained of) mild pain to left thumb and swelling. An x-ray of the left hand was ordered and the results were dislocation of the distal phalanx of the thumb. There may be a fracture through the base of the distal phalanx as well. Consider repeat radiographs following reduction. The resident was sent to an orthopedic doctor on 10/31/24 for left thumb pain and swelling post injury. The orthopedic notes stated Unable to do a closed reduction under local anesthesia. Short arm splint applied. A review of the care plans revealed an additional care plan for potential for significant injury related to fall (edited 11/15/24). Approaches revealed keep call light within his reach, and encourage to use it for assistance during transfers (edited 10/29/24), remind to observe safety at all times. Redirect prn (edited 10/29/24) and anticipate and meet his needs (edited 01/09/24). An interview was conducted with the MDS Coordinator on 12/04/24 at 10:16 AM. She was asked if there was a care plan for the actual fall with injury and she said she did not see one. She stated there should be a care plan for significant injury from the fall on 10/29/24 and there should be a care plan related to splint care but she did not see that on any care plan that she reviewed. The only update to the potential for significant injury related to fall care plan was encourage to use (call bell) for assistance during transfers. 25404 2) Review of the record revealed Resident #17 was admitted to the facility on [DATE]. A Side Rail Assessment Form dated 11/09/24, documented the use of bilateral side-rail use for Resident #17. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 12/02/24 at 11:20 AM revealed Resident #17 in a low bed with bilateral quarter rails noted and in use. Additional observations throughout the survey on 12/03/24 through 12/05/24, while passing by the resident's room, revealed the bed side rails in an upright position and in use. Review of the current care plans revealed no documentation of care plans that included the use of the bed side rails. During a side-by-side review of the record and interview on 12/05/24 at 12:23 PM, when asked if the use of bed side rails should be care planned, Staff C, MDS Coordinator, stated yes and explained that she was new at the facility and had noted an inconsistency in the care plans. The MDS Coordinator stated she was going to start adding the bed side rail use to the ADL (activities of daily living) care plans, as appropriate. The MDS Coordinator agreed with the failure to include the use of bed side rails in the care plans for Resident #17.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25404 Based on policy review, observation, interview, and record review, the facility failed to ensure complete and proper personal care for 1 of 1 sampled resident who had an urinary drainage device, as evidenced by the failure to perform hand hygiene prior to donning gloves, failed to provide peri-care (personal care) during catheter care, and failed to ensure proper catheter care for Resident #1. The findings included: Review of the policy titled, Foley Catheter Care and Maintenance revised 05/19/22, documented in part, Procedures: Foley (urinary drainage device) Catheter Maintenance . 4. Wash your hands with soap and water for at least 20 seconds, then apply gloves. 5. Using mild soap and water, or approved cleaner, clean your genital area. 8. Clean your urethra (urinary opening), which is where the catheter enters your body. 9. Clean the catheter from where it enters your body and then down, away from your body. Review of the record revealed Resident #1 was admitted to the facility on [DATE]. The record revealed the resident had an urinary catheter related to bladder obstruction. Review of the current Minimum Data Set (MDS) assessment dated [DATE], documented the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4, on a 0 to 15 scale, indicating severe cognitive impairment. This MDS also documented the resident was totally dependent upon staff for toileting and that the resident had an indwelling urinary catheter. Review of the current care plan initiated on 09/18/23 documented Resident #1 had the potential for complications related to the use of an indwelling catheter. This care plan was updated with a hand-written note that the resident was colonized with the bacteria E. Coli (Escherichia Coli, part of the normal human intestinal flora, but should not be part of the urinary system when proper care is provided). An observation on 12/02/24 at 12:34 PM revealed Resident #1 in bed with an Urinary catheter tubing noted with bedside drainage. An observation of personal care for Resident #1 was made on 12/04/24 beginning at 9:36 AM, with Staff E, Certified Nursing Assistant (CNA). The CNA was asked to do the personal care she would normally complete for Resident #1. The CNA gathered her supplies and donned gloves without performing any type of hand hygiene. The CNA applied soap to the cloth and cleaned the urinary catheter tubing, then wiped off the resident's left groin, then continued to clean the catheter tubing. The CNA rinsed and dried the tubing, checked to see if the resident had a bowel movement, which he had not, and completed her task by covering the resident. The CNA failed to complete any personal (peri) care for Resident #1. When asked if she was to provide peri-care as well, the CNA stated, Was I supposed to? When asked if she had done any type of personal care for Resident #1 that morning, the CNA stated, No this is my first round with him. When asked if she completed any type of hand hygiene prior to donning her gloves, the CNA confirmed she had not.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026 Based on interviews and record review, the facility failed to ensure that clinical nutritional assessments were completed within the scope of practice for 1 of 1 sampled resident reviewed for nutrition (Resident #30). This had the potential to affect 51 out of 60 residents on the facility's current census. The findings included: A review of the Certified Dietary Manager (CDM) scope of practice dated 01/20/20 showed the following: Gather Nutrition Data. Interview and identify client-specific nutritional needs/problems. Review nutrition screening data and calculate nutrient intake. Document in the medical record. Identify food customs and nutrition preferences based on race, culture, religion, and food intolerances. Utilize standard nutrition care procedures following ethical and confidentiality principles and practices. Participate in care conferences and review the effectiveness of nutrition care. Provide nutrition education. A Review of the Revised 2024 Scope and Standards of Practice for the Registered Dietitian Nutritionist by the Academy of Nutrition and Dietetics showed the following: The Registered Dietitian is responsible for reviewing reported nutrition screening data or conducting nutrition screening, if applicable; completing nutrition assessments; determining the nutrition diagnosis or diagnoses; developing care plans; implementing the nutrition intervention; evaluating the patient's/client's response; and supervising the activities of professional, technical, and support personnel assisting with the patient's/client's nutrition care. They also assign duties that are consistent with the individual scope of practice. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review showed that Resident #30 was admitted to the facility on [DATE] with diagnoses of Diabetes, Hypertension, Congestive Heart Failure and Anemia. The initial nutrition assessment was conducted on 01/25/24 and was completed by the facility's Dietician. The quarterly assessment dated [DATE] was completed by the CDM and revealed the daily nutritional requirements, nutritional need and protein and caloric requirement for Resident #30. The assessment was signed and completed by the CDM with no oversight or review by the Dietitian. The next quarterly assessment dated [DATE] was also completed by the CDM with no oversight or review by the Dietitian. An interview was conducted with the CDM on 12/03/24 at 11:45 AM. She stated the Dietician comes once a week and does the initial and annual assessments and she does the quarterly assessments. She stated the dietician looks over her assessments and she calls and emails him when she has a question but stated she does not think he signs off on the assessment after he looks at them. She stated the Dietician had given her a formula to use for nutritional needs for the residents. She has been doing the quarterly assessments for years. An interview was conducted with the Dietician on 12/04/24 at 1:00 PM. He stated he has been the Dietician at this facility for approximately [AGE] years. He comes into the facility on ce a week on Wednesday. He does breakfast rounds. When new admissions come in, the CDM calls him or texts him. He does the initial, annual and quarterly nutritional assessments on the residents with tube feedings, dialysis and weight loss. The CDM does the majority of the other quarterly assessments. She will text him of a weight loss or gain. He decides who will be on weekly weights. The CDM does the quarterly care plans and he does the annual and initial care plans. In a subsequent interview with the Dietician on 12/04/24 at 2:14 PM he stated he did not realize that the CDM should not do the quarterly assessments. He stated he looks at the assessments but does not acknowledge that he reviews them.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 25404 Based on observation, menu review, and interview, the facility failed to follow their approved menu for 1 of 2 meals observed, as evidenced by the failure to prepare all foods on the lunch menu on 12/04/24, and substituted with foods not on the menu, affecting sampled Residents #13 and #2, with the potential of affecting 4 of 56 residents who consume food. The findings included: Review of the approved lunch menu for 12/04/24 documented, in part, the provision of an alternate vegetable of corn on the cob, the mechanical soft vegetable of cooked carrots, and the alternate mechanical soft vegetable of lima beans. An observation of the posted lunch meal for 12/04/24 docmented the meat as BBQ ribs with a side of baked beans. The alternate meal was listed as fried fish with corn on the cob. During an observation of the lunch meal service on 12/04/24 beginning at 11:20 AM, Staff G, lead cook for the day, placed the prepared food on the steam table, to include in part, chicken thighs, green beans, pureed chicken, and pureed green beans. After completion of the the food temperatures at 11:35 AM, when shown the approved menu and asked about the documented corn on the cob, carrots, and lima beans, the cook stated those items had not been prepared, further stating, they (the residents) usually like the green beans instead of the carrots. The cook had no explanation for the lack of corn on the cob or lima beans. When asked about the chicken, the cook stated some of the residents liked the chicken instead of the fish. The cook also confirmed she did not have any ground or pureed fish for the alternate meals. During an interview on 12/04/24 at 12:20 PM, the Kitchen Manager/Certified Dietary Manager (CDM), was asked about the missing vegetables. The CDM stated she believed there was corn on the cob in the freezer but had no explanation as to why it wasn't cooked. The CDM confirmed there were no carrots or lima beans, but again had no explanation. Review of the Resident Dislikes List documented four of the 56 residents who consume food orally, had pork listed as a disliked item. The main entree for the 12/04/24 lunch meal was pork BBQ ribs. The fried fish was served to Resident #13, who disliked pork, and the other three residents who did not like pork received chicken, including Resident #2. During an interview on 12/04/24 at 12:25 PM, Resident #13 stated the fish was good. When asked about the alternate vegetable, she stated she would have enjoyed the corn on the cob. During an interview on 12/04/24 at 3:56 PM, the CDM confirmed the corn on the cob and carrots were missed during the lunch meal that day. The CDM stated they did not have lima beans, and further stated the mechanical soft alternate vegetable should have been corn, since the alternate vegetable was corn on the cob, and the alternate pureed vegetable should have also been corn. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/05/24 at 9:08 AM, Resident #2 confirmed he had chicken the previous day for lunch, and further stated he was not told what the alternate meal was. Resident #2 had a documented dislike of pork. The resident further confirmed he liked but was not offered the fried fish, the alternate that was documented on the menu.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 25404 Based on recipe review, observation, and interview, the facility failed to follow cooking instructions and ensure prepared fried fish was at a safe temperature, for 1 of 1 sampled resident who ordered that meal (Resident #13). The findings included: Review of the Production Recipe for the breaded cod, the fried fish on the lunch menu for 12/04/24, documented in part, Crunchy Breaded Cod Fillet 1. Deep fry from frozen at 360 degrees F for 3 to 5 minutes. Final internal cooking temperature must reach a minimum of 145 degrees F, held for a minimum of 15 seconds. Hot foods held for later service must maintain a minimum internal temperature of 135 degrees F. An observation of the lunch meal service was made on 12/04/24 beginning at 11:20 AM. Staff G, lead cook for the day, placed the prepared foods into the steam table and took the food temperatures. When asked about fried fish, the cook stated it would be fried a little later, as the resident who requested it was served on the last cart. At about 12:00 PM, Staff H, assistant cook for the day, fried three pieces of fish and placed them on the steam table. Staff failed to obtain a final temperature of the fried fish upon taking it out of the fryer. At 12:14 PM, Staff G, lead cook, took one of the three pieces of cooked fish from the steam table and placed it on a plate to put on the lunch tray of Resident #13. As kitchen staff were preparing to place plates on the tray to load onto the food cart, a request to obtain the temperature of the fish was made by the surveyor. The fried fish temperature was 125 degrees F. The lead cook told the assisting cook to fry the fish longer. After further cooking and surveyor intervention the temperature was 164 degrees F. During an interview on 12/04/24 at 12:20 PM the Kitchen Manager/Certified Dietary Manager (CDM) agreed staff failed to properly temp the fried fish upon completion of cooking, and failed to hold the cooked fish at a safe temperature.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on the facility policy, centers for disease control (CDC) review, observations and record review, the facility failed to ensure appropriate infection control practices by failure to implement enhanced barrier precaution (EBP) process for residents with wounds, and indwelling medical devices including feeding tubes, and foley catheter for 4 of 4 sampled residents, with the potential to affect 6 residents identified as needing EBP. This involved Resident #1, #20, #22, and #44. The facility failed to ensure appropriate hand hygiene during wound care. This involved (Resident #22). The facility failure to ensure appropriate hand hygiene during perineal/catheter care. This involved Resident #44. The findings included: The Policy reviewed, titled handwashing practices dated March 19, 2020, indicated handwashing shall be regarded by this organization as the single most important means of preventing the spread of infections. 1) all personnel shall follow our establishing procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. 2) appropriate of 20 seconds minimum handwashing must be performed under the following condition: F. after handling used dressings. H. after handling items potentially contaminated with blood, body fluids, accretions, or secretions. J. always after removing gloves. Review of CDC guideline updated date 04/02/24, explained, the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include Dressing, Bathing/showering, Transferring, providing hygiene, changing linens, changing briefs or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator. Wound care: any skin opening requiring a dressing and Tube Feeding. 1) Record review reveled Resident #22 was admitted to the facility on [DATE] with a diagnosis including Dementia. Review of the significant change Minimum Data Set assessment, reference date 11/07/24, indicated Resident #22 was rarely understood. No behaviors recorded. Review of the December 2024 medication administration record revealed a physician order of Jevity 1.5 calories at 45ml per hour for 22 hours daily. Additional review of physician orders, medication and treatment administration record, and care plans lacked evidence of the EBP process. Further review of care plans with revised date of 11/12/24, indicated all of Resident #22's nutrition and hydration needs were met via feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/02/24 at 9:46 AM Resident #22 was observed lying in bed, she was receiving tube feeding, there was no EBP in place; no signage, no Personal Protective Equipment kit (PPE kit). On 12/03/24 at 8:39 AM, an observation was conducted of Resident #22, as she was receiving tube feeding, there was no evidence of EBP in place. On 12/04/24 at 8:54 AM Resident #22 was observed lying in bed, receiving tube feeding, there was no EBP in place. On 12/05/24 at 10:20 AM, an interview process was held with the Infection Preventionist (IP), during that time, she was asked about the facility's Enhance Barrier Precaution process. The IP revealed, the facility did not have an EBP process in place until 12/04/24, after the surveyor's intervention. The IP was made aware for three days, Resident #22 did not have sn EBP process in place and she has tube feeding. The IP agreed. 2) Clinical record review revealed, Resident #44 was admitted to the facility on [DATE], with diagnosis including End Stage Renal Disease. Review of the quarterly Minimum Data Set assessment, reference date 08/29/24, documented a Brief Interview for Mental Status score of 03, which indicated Resident #44 was severely cognitively impaired. Under section M for skin status, it was recorded that Resident #44 had an unhealed pressure ulcer at a stage four. Review of physician orders dated 09/27/24, indicated to cleanse sacrococcygeal ulcer with normal saline, blot dry, apply messalt pad, then cover with hydro cellular foam dressing with silicone adhesive border daily and as needed. Review of the documented wound measurements dated 12/02/24, showed evidenced that the sacral wound was measured as followed: 7.5cm x 7.5 cmx 2.5cm, 100% granulation, 0% slough, 0% eschar, no odor, undermining, no tunnelling. An observation was made of Resident #44 on 12/02/24 at 10:47 AM, she was observed lying in bed alert, there was no EBP process in place (no signs, and no PPE kit). On 12/03/24 at 9:32 AM, an observation was made in Resident #44's room, there was no EBP process in place. On 12/04/24 at 9:09 AM, an observation was conducted on Resident #44 while Staff A, a License Practical Nurse, was performing the wound care and Staff I, a Certified Nursing Assistant, was assisting in holding and turning Resident #44 during the care. The mentioned staff did not wear a gown. As Staff I turned and held Resident #44 to her side, Staff I's uniform was observed touching the resident. As Resident #44 turned, the nurse removed the old dressing, the sacrococcygeal was observed with a huge open wound and drainage. Staff A cleansed the wound with normal saline, she removed the soiled gloves, and applied new gloves without hand hygiene in between gloves changes. Subsequently she patted dry the wound, she removed her gloves, and applied new gloves, without hand hygiene in between. She then proceeded to pack the wound with messalt dressing, covered the wound with gauze, and foam dressing. She removed her gloves and applied new gloves, without hand hygiene in-between gloves changes. During the wound care process, Staff A's uniform was observed touching the bed linens as she leaned over to get to the wound. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106018	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glades Health Care Center	230 South Barfield Highway Pahokee, FL 33476

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/04/24 at 12:06 PM, an interview was held with Staff A; an inquiry was made regarding EBP process. Staff A voiced her understanding of EBP was when touching bodily fluids, or saliva during patient care, staff were to wear gloves. Staff A voiced she was never told to wear gowns during wound care. Staff A explained, she had asked her manager about wearing gowns during wound care back in 2021 (whether nurses needed to wear a gown during wound care), but was told, this was not part of the facility's policy. During further interview, the Surveyor spoke to Staff A regarding the facility's policy, which indicated staff were to conduct handwashing after removing gloves. She agreed that she did not conduct hand hygiene in-between gloves changes during the wound care. On 12/05/24 at 10:20 AM, an interview was held with the IP. During that time the IP was made aware that for three days (as of 12/02/24, 12/03/24 and 12/04/24), Resident #44 did not have EBP process in place and she has an open wound. The IP agreed. During that time, the IP provided a list of residents who had indwelling medical devices and wounds, which included: Resident #20 (tube feeding), and Resident #28 (tube feeding). Review of Resident #20's annual comprehensive assessment, reference date 09/10/24, revealed he was admitted to the facility on [DATE] with diagnosis that included Dementia. This assessment showed a Brief Interview for Metal Status score of 01, which indicated Resident #20 was severely cognitively impaired. On 12/02/24 at 12:46 PM, an observation was conducted of Resident #20. There was no EBP process was in place. Review of Resident #28 quarterly comprehensive assessment reference date 09/30/24, revealed, the resident was admitted to the facility on [DATE], with diagnosis that included: Dementia. This assessment showed, the resident was rarely understood. No behaviors recorded. For three days, during the survey process (12/02/24, 12/03/24, and 12/04/24) there was no EBP process observed for Resident #28. 25404 3) Review of the record revealed Resident #1 was admitted to the facility on [DATE]. The record revealed the resident had an urinary catheter related to bladder obstruction. Review of the current Minimum Data Set (MDS) assessment dated [DATE], documented the resident was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 4, on a 0 to 15 scale, indicating the resident as severly cognitively impaired. This MDS also documented the resident was totally dependent upon staff for toileting and that the resident had an indwelling urinary catheter. Review of the current care plan initiated on 09/18/23 documented Resident #1 had the potential for complications related to the use of an indwelling catheter. This care plan was updated with a hand-written note that the resident was colonized with the bacteria E. Coli (Escherichia coli, part of the normal human intestinal flora, but should not be part of the urinary system when proper care is provided). An observation on 12/02/24 at 12:34 PM revealed Resident #1 in bed with an Urinary catheter tubing noted with bedside drainage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106018	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 12/02/24 at 12:34 PM and on 12/03/24 at 10:01 AM revealed Resident #1 in bed with the urinary drainage device to bed side drainage. There was no observed sign for Enhanced Barrier Precautions (EBP) or any personal protective equipment, other than gloves, readily available (Photographic Evidence Obtained). An observation of personal care for Resident #1 was made on 12/04/24 beginning at 9:36 AM, with Staff E, Certified Nursing Assistant (CNA). The CNA was asked to perform the personal care she would normally complete for Resident #1. The CNA gathered her supplies and donned gloves, but no other PPE (personal protective equipment). The CNA provided direct care to Resident #1. During an interview on 12/04/24 at 11:02 AM, when asked if she knew what Enhanced Barrier Precautions or what EBP was, Staff E, CNA questioned, Like washing your hands? When asked about the use of PPE during care for Resident #1 who had an indwelling catheter, the CNA questioned if she needed to wear goggles, a hair net, and a gown. When asked if there were any gowns available for use, the CNA stated yes, and took the surveyor to the supply area at the East nurse's station and was unable to find any. The CNA went to Central Supply and asked the Central Supply person for gowns, and there were none there. The Central Supply person found boxes of disposable gowns in the main supply area in the back hall of the facility. When asked about EBP the Central Supply CNA was unaware of what it was. During an interview on 12/04/24 at 11:11 AM, when asked if she was aware of EBP, Staff F, Licensed Practical Nurse (LPN) stated, When a resident has a Foley or something and has infection we put them on contact precautions. The LPN was unaware and unable to explain PPE use related to Enhanced Barrier Precautions.