STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105175	A. BUILDING _____ B. WING _____	**06/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLANTATION NURSING & REHABILITATION CENTER	**4250 NW 5TH ST PLANTATION, FL 33317**

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 0551 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give the resident's representative the ability to exercise the resident's rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the rights of a medically fragile child, for 1 of 3 sampled residents reviewed, Resident #1, as evidenced by failure to obtain consent from the legal representative to perform a haircut on Resident #1. The findings included: Review of the facility submitted Federal 5-Day Incident Report, dated 05/27/20, documented Resident #1's hair had been cut without consent from the legal guardian. The facility interviewed staff identified as working with Resident #1 between 05/25/20 and 05/27/20 and all stated they were unaware of who cut Resident #1's hair. Review of Resident #1's clinical record revealed he was totally dependent for all activities of daily living, was non-verbal, non-ambulatory, hearing and visually impaired, receives all nutritional and hydration needs via a feeding tube and is oxygen dependent via a [MEDICAL CONDITION]. On 06/03/20 at 2:30 PM, a telephone interview was conducted with Resident #1's legal representative, a Child Protective Investigator (CPI), who stated she would be the person to be called to obtain consent for any treatment or procedure for Resident #1, to include obtaining consent for a haircut. She stated she was notified by Resident #1's parent on 05/27/20, the child's hair had been cut and she was not called by anyone at the facility to obtain consent to do so. On 06/03/20 at 3:22 PM, a telephone interview was conducted with Resident #1's father who stated he was the one who called Resident #1's CPI to inform her Resident #1's hair had been cut without their consent. He further stated they have let their son's hair grow out for [AGE] years now, however a reason was not verbalized. On 06/03/20 at 3:31 PM, a telephone interview was conducted with Resident #1's mother who stated a supervisor from the facility notified her on 05/27/20 that someone cut her son's hair. She stated she did not consent to cutting his hair and expressed that she was upset about it. On 06/04/20 at 9:15 AM, an interview was conducted with the facility Administrator who stated after their investigation into the hair cutting incident with Resident #1, they know it was a staff member who cut the resident's hair, however they are unable to definitively determine who it was. He stated staff knows you do not cut a child's hair without consent from the parent or legal guardian. He further stated they have a barber that comes to the facility to cut the children's hair, however they have not allowed him into the building due to COVID-19 visitation restrictions of only essential workers being allowed access into the facility. He stated when the barber does come to cut or trim the children's hair, they always obtain consent from the parent or guardian because that is the facility protocol. On 06/04/20 at 10:05 AM, an additional interview was conducted with the Administrator who stated their investigation revealed on the night shift from 7 PM (05/25/20) to 7 AM (05/26/20), the Respiratory Therapist (RT), Staff 'A', when she came on shift had observed Resident #1's hair to be cut shorter than prior observations and she brought it to the attention of Licensed Practical Nurse (LPN), Staff 'B'. Staff B and Staff A had both stated they assumed there was consent to cut his hair. The Administrator had stated on 05/25/20 that the Occupational Therapist (OT), Staff 'C', observed Resident #1's hair at 1:00 PM to be full length and styled in a bun on the top of his head. With this information, the Administrator stated they determined that the child's hair had been cut between 1:00 PM and 7:00 PM on 05/25/20. The Administrator further stated on 05/26/20, the Social Worker went into the resident's room and observed hair residue around the resident. On 06/04/20 at 12:01 PM, an interview was conducted with LPN Staff 'D', who was Resident #1's assigned nurse on 05/26/20 from 7:00 AM to 7:00 PM. She stated she had only cared for Resident #1 once before but did recall he had a full head of hair down below his shoulders and it was styled in a bun on top of his head. She stated at around 2:30 PM, she reached out to touch Resident #1's hair and felt that it was shorter and stated she was surprised his hair had been cut. She stated she immediately went to the nursing supervisor's office and informed the nursing supervisor and 2 other managers in the nursing office of her observation. She stated the managers expressed they had not received authorization to have the resident's hair cut or trimmed. On 06/04/20 at 1:00 PM, an interview was conducted with the pediatric Social Worker (SW), who stated she received a report on 05/26/20 at approximately 2:30 PM from LPN Staff 'D' that Resident #1's hair was shorter. She stated, along with the Respiratory Therapy Supervisor, they went to Resident #1's room and observed the resident's hair to have been cut from elbow length hair to chin length hair. She stated she had observed the resident's hair to usually be in a bun or ponytail. She stated when she observed his hair at this time, it was observed to be sawed off like cutting off a ponytail at a rubber band with the ends being jagged. She further stated she observed pieces of hair remaining on the pillowcase. She stated she looked in the wastebasket and found no evidence of a haircut. Additionally, she was unaware of any consent for a haircut. She discussed this with the Nurse Managers and they were unable to find any documentation of consent to cut the resident's hair. She further stated at approximately 3:30 PM, she went to inform the Administrator to discuss the incident and confirmed there was no consent to cut Resident #1's hair. On 06/05/20 at 10:10 AM, an interview was conducted with the Respiratory Therapist Supervisor who stated Resident #1's hair was long and usually wrapped up in a bun on the top of his head. She stated, on 05/26/20 when she went to the resident's room with the SW, they observed his hair to be cut and pulled up into a ponytail on the top of his head and secured by a piece of rubber glove. She further stated she was shocked that this had happened as it was facility protocol to obtain permission from the parents or guardian to do anything with the children. On 06/05/20 at 12:30 PM, an interview was conducted with Occupational Therapist (OT) Staff 'C', who stated she had worked with Resident #1 a few times prior to their session on 05/25/20 and noted that his hair was styled like it normally had been, placed in a bun on top of his head, further stating his hair was shoulder length and curly when it was not up in a bun. She stated their session ended around 1:00 PM. She further stated she was in disbelief that his hair had been cut as it is the facility protocol to obtain permission prior to cutting a child's hair.

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

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