

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/10/2024
NAME OF PROVIDER OR SUPPLIER Sunrise Point Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1775 Huntington Lane Rockledge, FL 32955	

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)
<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39943</p> <p>Based on interview, and record review, the facility failed to ensure a resident's wishes related to health care treatments and procedures at the end of life were accurately recorded and readily available to nursing staff. As a result, the nursing staff failed to honor an Advance Directive that reflected the decision to withhold Cardiopulmonary Resuscitation (CPR) for 1 of 2 residents reviewed for CPR, of a total sample of 6 residents, (#1).</p> <p>These failures contributed to resident #1 receiving CPR against his wish for a natural, dignified death. There was likelihood resident #1 experienced severe pain, and could have suffered broken bones, organ damage and a prolonged dying process.</p> <p>On [DATE], resident #1's sister/Healthcare Proxy signed a State of Florida Do Not Resuscitate Order (DNRO) and placed her brother in Hospice. He was readmitted to the facility on [DATE], at which time the DNRO had not yet been signed by the physician. On [DATE] the Hospice nurse handed the completed and signed DNRO form to the South Court Unit Manager (UM). The UM entered the DNRO Physician order in the Electronic Medical Record (EMR) and flagged the paper order in the Hospice chart instead of the Code Status Binder. Upon receipt of the DNRO form, per facility policy, the UM should have entered the order into the EMR, scanned the DNRO form into the EMR and placed the paper copy in the Code Status binder on the unit. The Code Status Binder was a quick reference the nursing staff utilized to confirm the residents' code status in case of an emergent situation.</p> <p>On [DATE], at approximately 10:00 PM the attending nurse, Licensed Practical Nurse (LPN) D found resident #1 unresponsive with no pulse or respirations. LPN D checked the EMR for physician orders and headed to the North Court to find the Director of Nursing (DON) who was working as a floor nurse at that time. LPN D informed the DON resident #1 expired, was in hospice and a DNR. The DON went to the South Court and LPN E informed her resident #1 had a Physician's order for DNRO in the EMR but no DNRO form scanned into the EMR nor placed in the Code Status Binder. The DON instructed LPN E to call 911 and have the crash cart brought to resident #1's room. The DON and LPN D went to resident #1's room and initiated CPR. CPR continued until Emergency Medical Services (EMS) arrived, assessed the resident, and pronounced the resident's time of death to be 10:20 PM.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility's failure to honor the right to choose withholding of lifesaving interventions placed all residents with a DNRO at risk for serious psychosocial harm, physical trauma, and prolonged undignified death from unwanted resuscitation efforts. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed on [DATE], and the facility corrected the noncompliance at F678 on [DATE]. The noncompliance at F678 was determined to be past noncompliance.</p> <p>Findings:</p> <p>Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included cerebral ischemia, chronic obstructive lung disease and respiratory failure with hypoxia.</p> <p>Review of the Minimum Data Set Significant Change in Status assessment with Assessment Reference date of [DATE] revealed resident #1 had a Brief Interview for Mental Status score of 00 which indicated severe cognitive impairment. The document indicated the resident received Hospice services.</p> <p>Review of resident #1's medical record revealed a copy of the State of Florida DNRO canary yellow form signed by the resident's sister/Healthcare Proxy on [DATE]. The form was signed by the physician on [DATE]. The document showed the sister's signature under the statement, Based upon informed consent I, the undersigned hereby direct that CPR be withheld or withdrawn. The proxy box was checked. The physician's statement read, . I direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.</p> <p>Review of the physician's order dated [DATE] read, Do Not Resuscitate.</p> <p>On [DATE] at 4:25 PM, the South Court UM stated when resident #1 returned from the hospital he was a full code. She explained the Hospice nurse informed her that although resident #1's sister had signed the DNRO form, the physician had not signed it and she would bring it to the facility on ce it was signed. The UM stated she received the now complete DNRO form from Hospice on [DATE]. She confirmed she entered the Physician's order for DNR in the EMR. She explained she then incorrectly placed the DNRO form in resident #1's Hospice chart instead of the Code Status binder. The UM recalled, I remember that I flagged it so I would get back to it. I am not sure what happened after that. The UM noted DNR forms were usually completed by the Social Worker or Admissions staff and were scanned into the electronic medical record. The UM stated scanning the document into the electronic medical record had always been the facility's process, but the new process was to place the document in the Code Status binder. She acknowledged she had received training and was aware of the process to place the DNRO form into the Code Status binder. She stated resident #1's canary yellow DNRO form was later found lying on the chart rack instead of being in the Code Status binder.</p> <p>On [DATE] at 5:04 PM, Registered Nurse (RN) A stated on [DATE] he worked on the North Court with the DON when LPN D informed resident #1 had expired. He said the DON and LPN D proceeded to the resident's room. RN A explained he went to the resident's room shortly after and the DON instructed him to take over chest compressions so she could call Hospice to clarify resident #1's code status. RN A stated he performed CPR for about ,d+[DATE] minutes before EMS arrived. He recalled EMS did not perform CPR and stopped the code. He explained the DON came back to the room at that moment and said resident #1 was not to be resuscitated.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 5:30 PM, Certified Nursing Assistant (CNA) B stated she was assigned to resident #1 on [DATE]. She recalled resident #1 was awake when she provided incontinence care between 9:00d+[DATE]:30 PM. She stated CNA F checked on him after she provided incontinence care, and he was watching television at that time.</p> <p>On [DATE] at 12:34 PM, during a telephone interview, the DON who no longer worked at the facility, described the sequence of events on [DATE]. She stated on [DATE] she worked the 3 PM to 11 PM shift. She said she worked extra shifts to avoid using agency and it gave her a chance to work with the staff and get to know the residents better. She recalled LPN D came to the unit and informed her resident #1 was not breathing, did not have a pulse and was a DNR. The former DON remembered as she proceeded to resident #1's room, LPN F said resident #1 was a full code as there was no canary yellow DNR form in the Code Status binder. She said, I looked for the Hospice binder but could not find it, so I looked in the medical record for the scanned DNR copy. I questioned whether the physician's DNR order was entered in error as there was no yellow DNR form located. She indicated she and LPN D proceeded to the resident's room and started CPR. She explained when RN A arrived, she instructed him to take over chest compressions and she left to verify the resident's code status with Hospice. She said Hospice services verified resident #1 had advance directives for DNR. She recalled when she returned to resident #1's room, EMS had already stopped the code.</p> <p>On [DATE] at 4:36 PM, during a telephone interview resident #1's sister stated her brother went on Hospice services and she signed the DNR form. She explained she wanted her brother to die in peace and not endure any prolonged suffering. She said she was informed the facility performed CPR against their wishes and, That made me very upset because he was a DNR and then they did do it after I said not to do it. It really irritates me.</p> <p>On [DATE] at 4:04 PM, an interview with the Administrator, Interim DON, Assistant Director of Nursing (ADON), and Corporate Nurse Consultant was conducted to review the incident. The Administrator stated a full investigation was completed following the incident with resident #1 and all nurses involved were suspended pending the investigation. He said the DON was terminated after the investigation was completed and LPN D who was an agency nurse was put on the Do Not Return list. The Administrator said the root cause was the Code Status binder was not updated. The ADON stated the Code Status binder was a new process that began in February and all nursing staff were educated. She said the nurse who received the canary yellow DNRO form should have placed the form in the Code Status binder. The Administrator said the Social Service Director (SSD) should have verified the Code Status of all residents monthly.</p> <p>On [DATE] at 5:30 PM, the SSD stated she previously completed monthly audits of resident charts for code status but now did them weekly. She explained the process included review of the Code Status on the profile and ensured it matched the order from the doctor. She said now she also checked care plans and verified the code sheet was scanned into the electronic medical record. The SSD stated all resident charts were reviewed in morning meetings. The SSD acknowledged she missed resident #1's order and said, I was getting behind in my charting and wanted to create a more effective process.</p> <p>Review of Advanced Directives Code Status policy dated ,d+[DATE] read: Do Not Resuscitate (DNR)- A DNR code status would indicate the person would not want CPR performed and would be allowed to die naturally if their heart stopped beating and/or they stopped breathing.</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's corrective actions were verified by the survey team and included the following:</p> <p>On [DATE], the Attending Physician, Medical Director, Administrator, and family were notified of the incident and an investigation was initiated.</p> <p>On [DATE] an Ad Hoc Quality Assurance Performance Improvement (QAPI) was completed with the Medical Director, Administrator, Assistant Director of Nursing and additional administrative staff members on the adherence to policy and procedures for Advanced Directives code status related to the Electronic Health record, Code Status binders, following physician orders and a review of the root cause analysis. The ADON completed an audit of Code Status binders for current residents residing in the facility to validate DNR forms were in the appropriate binder. No additional concerns were identified.</p> <p>On [DATE] and [DATE], and [DATE], QAPI meetings were held with the Administrator, Director of Nursing, Medical Director, and administrative staff. Education, audits, and drills were reviewed and revised as indicated.</p> <p>On [DATE] to [DATE], 27 of 29 licensed nurses were educated on Advanced Directives Code Status standards and guidelines with emphasis on updating Code Status binders with the appropriate form when Code Status orders were obtained, ensure DNR form was scanned into the medical record and on following Code Status orders. Code Status Competencies were completed with licensed nurses to validate education received. Two of 29 nurses were currently on leave and were to be educated prior to return to work. Any contracted nurses at the facility on assignment will receive the above education prior to starting their shift through an agency orientation packet. New hired nurses at the facility will receive the above education during orientation and prior to working an assignment.</p> <p>From [DATE] through [DATE], a total of twenty-nine mock code drills were completed to ensure competency of Code Blue process. All nurses attended the drill and were given a posttest after the drill was completed.</p> <p>On [DATE], the Social Services Director received education on Advanced Directives Code Status standards and guidelines with emphasis on Social Services' roles and responsibilities from Regional Nurse Consultant.</p> <p>Weekly audits were conducted to ensure the EMR and Code Status binder matched, knowledge checks with 5 nursing staff to conduct knowledge of training, new admissions/readmissions, and residents with changes in Code Status orders verified three times a week for accuracy.</p> <p>Reviews completed [DATE], [DATE], [DATE], [DATE], [DATE] with 100% compliance.</p> <p>From [DATE] to [DATE], the facility took actions to reduce the risk of future occurrences. All staff were educated regarding the policy and procedure related to Advanced Directives with a focus on Code Status and following the Physician's orders with post-test. New Hire staff orientation to include Code Blue response and verification of Code Status in EMR and Code Status Binder, Code Status and Advanced Directives confirmed at the time of admission and orders placed in EMR. Code Status and Code Blue Drills (includes verifying Code Status, Advance Directives and DNRO).</p> <p>(continued on next page)</p>		

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<p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Interviews conducted on [DATE] to [DATE] with staff members (8 Certified Nursing Assistants, 4 Licensed Practical Nurses, 5 RNs, and the SSD) indicated they were knowledgeable of Advance Directives and where to verify the Code Status in the EMR and Code Status binder prior to providing CPR.</p> <p>The surveyors validated the education with attendance sheets for Code Blue drills and in-services. Review of QAPI audits revealed the audits were completed as described per Performance Improvement plan.</p> <p>The resident sample was expanded to include eight additional residents who elected DNR status. Interviews and record reviews revealed no concerns for residents #7, #8, #9, #10, #11, #12, #13, #14 related to Advance Directives. Residents #13 and #14 expired in the facility and their DNR status was honored. Based on the facility's corrective actions, the survey team determined the facility was in substantial compliance as of [DATE].</p>		