STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105250	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Point Health and Rehabilitation Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192 Based on interview, and record review, the facility failed to report an allegation of abuse made by a resident within the required timeframe and failed to report and investigate an allegation of abuse made by a resident to the state agency (SA) for 2 of 6 residents reviewed for abuse, of a total sample of 15 residents, (#4, and #10). Findings: 1. Review of resident #4's medical record revealed he was readmitted to the facility on [DATE] with diagnoses of encephalopathy, hemiplegia and hemiparesis (muscle weakness and paralysis to one side of the body) following a stroke, type 2 diabetes and chronic pain. Encephalopathy is a change in how the brain functions. It may cause confusion or agitation or temporary disturbance or it could permanently damage the brain, (retrieved from www.clevelandclinic.org on 1/26/25). Review of resident #4's Minimum Data Set (MDS) annual assessment with Assessment Reference Date (ARD) 11/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated he was cognitively intact. The MDS assessment noted no rejection of evaluation or care necessary to obtain goals for health and well-being. The MDS showed resident #4 was dependent on staff for toileting, shower/bathe, upper and lower body dressing and personal hygiene. He required substantial assistance for oral hygiene. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/09/25 at 11:05 AM, in a joint interview with the Administrator (NHA), the Director of Nursing (DON) and the Regional Nurse Consultant (RNC) , the NHA stated he was the Abuse Coordinator and explained an immediate report was submitted to the SA on 12/31/24 for an allegation of physical abuse made by resident #4. He explained due to an odd set up in resident #4's room, turning off the call light was very difficult to get to because the Certified Nursing Assistants (CNA) had to lean on his bed to turn the call light off. He indicated resident #4 reported on 12/26/24 his assigned CNA smacked his hand. He explained a skin assessment was done and no injuries were noted. The NHA stated the CNA had already left for the day, but she was called and informed she was suspended until the investigation was completed. The NHA indicated the DON interviewed resident #4 but was unable to interview his roommate because he was not interviewable, due to severe cognitive impairment. The DON explained the assigned CNA told her when she was changing resident #4's brief, he touched her breast but she denied hitting the resident. The DON stated Licensed Practical Nurse (LPN) B entered two progress notes on 12/26/24 regarding resident #4's inappropriate behavior, one at 10:06 AM, and one at 4:50 PM, and LPN B reported this to her that same day. Review of Registered Nurse (RN) A's witness statement dated 1/02/25 revealed, On the night of Thursday December 26, 2024 this nurse was passing medication to his assigned residents when he heard the sounds of an altercation taking place behind him. This nurse moved to investigate. He heard [CNA C] say something like You will not touch me. This nurse moved to separate the two when [resident #4] mentioned that [CNA C] had hit him. Once [CNA C] was out in the hall, this nurse asked if she had hit [resident #4] to which [CNA C] answered yes but clarified she had forcefully pushed [resident #4]'s hand away from her and that he had been trying to touch her in an inappropriate way. This nurse went to ask [resident #4] what happened. He stated that he had touched [CNA C]'s stomach by accident and that [CNA C] had hit his hand away. The other nurse on the floor that night [LPN B] then took [CNA C] to the DON's office to report the incident. The witness statement from LPN B dated 1/02/25 was included in the 5-day report submitted to the SA on 1/07/25. The statement read, I was sitting at nurses' station while CNA [C] was in resident's room. CNA's voice got louder and stated, Do not touch me like that. Do not even do that to me. The nurse asked the CNA did you just hit him? The CNA stated yes, he just grabbed my breast. LPN B's statement included that she asked CNA C to walk to the DON's office. Review of the witness statement from CNA C dated 1/03/25 mentioned she was changing resident #4's brief when he decided to put his hand over her breast. She described she pushed his hand off her breast and reported it to his nurse and the DON. The SA 5- day report included an interview by the DON with resident #4 which read, Resident stated he touched [CNA C]'s stomach when she leaned over, and she pushed his hand away. Then the resident later stated that the CNA slapped his hand away. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the interview on 1/09/25 at 11:05 AM, the DON stated the information included in the written statements about CNA C hitting resident #4 was not relayed to her on 12/26/24. She explained it was not until 12/31/24 when resident #4's assigned CNA reported resident #4 said he was hit by CNA C on 12/26/24. She indicated RN A or LPN B did not report CNA C hit resident #4. She indicated it was not handled as a physical abuse allegation and an investigation was not initiated on 12/26/24. She mentioned when LPN B and CNA C spoke to her, she saw it as a behavior issue as there was history of the same behavior in the past. The RNC stated there was a care plan for his behavior which had been last updated on 11/08/24. The NHA explained abuse allegations were reported to the appropriate agencies within 2 hours of learning about the incident and 24 hours for neglect or misappropriation. When asked about the two nurses not reporting that CNA C hit the resident on the day of the incident, there was no response from the NHA or the DON. The NHA explained education of staff was ongoing and mentioned they had challenges ensuring staff understood the education. 2. Review of resident #10's medical record revealed she was readmitted to the facility on [DATE] with diagnoses of bladder cancer, cirrhosis of liver, and heart failure. Review of resident #10's MDS quarterly assessment with ARD 9/30/24 revealed a BIMS score of 15 out of 15, which indicated she was cognitively intact. The MDS assessment noted no rejection of evaluation or care necessary to obtain goals for health and well-being. The MDS showed resident #10 was dependent on staff for toileting, shower/baths, upper and lower body dressing and personal hygiene. Review of the Grievance Log revealed two grievances were filed by resident #10 in October 2024. A Grievance and Comment Form dated 10/18/24 taken by the Social Services Director read, [Resident #10] requesting for CNA [name] not to provide care. The DON was listed as the person investigating the complaint. The follow up read, CNA will not be assigned to resident. A Grievance and Comment Form dated 10/31/24 read, CNA very rough. Needs help to learn how to help turn, need help to roll over and she pushes very hard. Had this problem before. I cried out. The result of the investigation cited, Corrective Action to Employee. The form was signed by the DON and the SSD. On 1/08/25 at 3:59 PM, the Social Services Director confirmed she was the grievance officer. She indicated she spoke to resident #10 on 10/18/24 and resident shared the CNA did not provide good customer service. She explained residents requested changes of staff for various reasons which could include personality conflict, call light response or any customer service issue. She stated she asked resident #10 if she got hurt and resident responded no. the Social Services Director stated the grievance filed on 10/31/24 was not reported to the SA but confirmed the DON took disciplinary action with the employee. The Social Services Director explained she was not involved in determining what constituted abuse. Review of the Reportable Event Log for October and November 2024 revealed no events listed for resident #10. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/09/25 at 3:35 PM, the NHA and DON did not reply to why resident #10's allegation of abuse was not reported and investigated by the facility. The NHA stated they did not discuss the entire grievance details during their morning meetings and only identified the department or person who would be assigned to investigate. The DON stated she interviewed the CNA, took corrective action and provided education to her. Later, at 5:00 PM, the NHA stated the DON could not find the corrective action or any documentation for this employee or the incident. Review of the facility Resident Right-Grievances policy dated 11/7/24 read, . immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the Administrator of the provider; and as required by State law; Review of the facility Abuse, Neglect and Exploitation policy revised on 11/16/23 revealed the purpose was to provide protection for the health, welfare and rights of each resident. The policy read, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect, or exploitation occur. The investigation included identifying and interviewing all involved including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations. Providing complete and thorough documentation of the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The document included alleged violations would be reported to the Administrator, state agency and other required agencies immediately, but not later than 2 hours after the allegation was made, if the events involved abuse or resulted in serious bodily injury. The policy revealed the facility would analyze the occurrence to determine why abuse occurred and make changes needed to prevent further occurrences, and train staff on changes made with demonstration of staff competency after the training was implemented.