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	08/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Point Health and Rehabilitation Center	1775 Huntington Lane Rockledge, FL 32955

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40892 Based on observation, interview, and record review, the facility failed to conduct medication self-administration assessment to ensure safety for 1 of 1 resident reviewed for self-administration of medications, of a total sample of 38 residents, (#47). Findings: Resident # 47 was admitted on [DATE] to the facility and then readmitted on [DATE] with diagnoses including cerebral infarction (stroke), unspecified glaucoma, asthma, and shortness of breath. Review of the Minimum Data Set (MDS) admission assessment with an assessment reference date of 4/30/24 revealed resident #47 had a Brief Interview for Mental Status score of 00 out of 15, which indicated she was severely cognitively impaired. On 8/06/24 at 11:20 AM, resident #47 was observed lying back in bed watching television. Her bedside table was over her lap, with personal items, including a 15 milliliter (ml) Afrin nasal spray. The resident said she used the nose spray because her nose got stuffy sometimes. On 8/06/24 at 11:30 AM, the resident's bedside table was observed with License Practical Nurse (LPN) B, her primary care nurse. She acknowledged the Afrin nasal spray 15 ml unsecured on her table. A review of the resident's physician orders with LPN B revealed no orders for the Afrin nasal spray found on the resident's overbed table. LPN B explained for someone to self-administer medications, they must have a physician's order and a self-administration evaluation completed. LPN B confirmed there was no physician's order for the Afrin nasal spray and that the resident had not completed a self-administration evaluation. On 8/06/24 at 11:39 AM, the Director of Nursing (DON) stated the self-administration assessment should be completed to ensure the resident could safely self-administer medication. A review of the facility's policy and procedure for Resident Self-Administration of Medication, dated 11/2020, revealed, A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48878 Based on observation, interview, and record review, the facility failed to honor resident's rights to choose their preferred bathing preferences for 1 of 3 residents reviewed for choices, of a total sample of 38 residents, (#81). Findings: Review of the medical record revealed resident #81 was admitted to the facility on [DATE] from the hospital. Her diagnosis included end stage renal disease, type II diabetes, heart failure, and dependence on renal dialysis. Resident #81's Admission Minimum Data Set (MDS) with an assessment reference date of 6/27/24 revealed the resident scored 15 out of 15 on the Brief Interview for Mental Status indicating she did not have any cognitive impairment. The MDS assessment also indicated resident #81 required substantial/maximal assistance with bathing, it was very important to her to choose between a shower and bed bath, and she participated in the assessment and goal setting. It also revealed the resident did not exhibit behavior symptoms or rejection of care that was necessary to achieve the resident's goals for health and well-being. Resident #81's Nursing Readmission Screen dated 6/20/24 noted the resident preferred a shower three times a week in the evening. Review of resident 81's Certified Nursing Assistant (CNA) Kardex added on 8/07/24 noted the resident preferred a shower on Wednesday and Fridays in the evening. Review of resident #81's medical record revealed an activities of daily living self-care performance deficit care plan was initiated on 6/25/24 and revised on 8/07/24 that noted the resident preferred a shower on Wednesday and Fridays in the evenings and required substantial/maximal assistance by one staff with bathing. It also noted the resident required a mechanical lift for transfers. The bathing task report for resident #81 showed she received only three showers from 7/10/24 to 8/08/24, on 7/31/24, 8/04/24, and 8/07/24. The report noted the resident received bed baths on 23 of 29 days since she was admitted . On 8/06/24 at 1:02 PM, resident #81 stated she was only given bed baths but preferred showers. She conveyed she had told the staff she preferred showers, but they told her she was unable to have showers, only bed baths. She stated she did not care what day or time they were scheduled, but would just like to have a shower. She stated her hair was not clean and was only washed once since she was admitted . She expressed that she celebrated how good it made her feel when she received her one and only shower from the staff last week. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/24 at 4:41 PM, the Assistant Director of Nursing (ADON) accessed resident #81's medical record and confirmed the Kardex, care plan, and nursing admission assessment indicated the resident's bathing preference was showers on Wednesday and Fridays in the evenings. The ADON accessed the resident's bathing task report and acknowledged the resident received only three showers in the past 30 days on Wednesday 7/31/24, Sunday 8/04/24, and Wednesday 8/07/24 with one day documented as the resident refused to be bathed. She expressed the resident's choices were not honored and she should have received showers instead of bed baths. She acknowledged the importance of ensuring the resident received her preferred means of bathing, as it was the resident's right. The facility's Resident Showers policy, dated November 2020 read, It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice .Residents will be provided showers as per request .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51023 Based on interview and record review, the facility failed to request a Preadmission Screening and Resident Review (PASARR) level 1 evaluation for 3 of 5 residents reviewed for PASARR, of a total sample of 38 residents, (#15, #46 & #55). Findings: 1. Resident #46 was admitted to the facility on [DATE]. His diagnoses included anxiety, hypertension and schizophrenia. Review of resident #46 Minimum Data Set (MDS) dated [DATE] revealed a diagnosis of schizophrenia. The MDS assessment also revealed the resident was on antipsychotic medications listed under the section for high-risk drug class medications. Review of the resident's orders revealed an order for Quetiapine Fumarate 50 milligrams (mg) twice daily and 150 mg at bedtime. The care plan for resident #46 listed him as being at a risk for complications related to the use of psychotropic drugs; the antipsychotic which was initiated 12/17/20. The care plan indicated the resident has a tendency to distort and confabulate information/statements related to schizophrenia/schizoaffective disorder initiated on 5/17/24. Review of resident #46's PASARR dated 11/25/20 under Section 1 part A; mental illness or suspected mental illness, revealed a handwritten note of N/A and the diagnosis of anxiety and Schizophrenia were not selected. 2. Resident #15 was admitted to the facility on [DATE]. His diagnoses included cerebral atherosclerosis, schizoaffective disorder (bipolar type), dementia with agitation, epilepsy, mood disorder, anxiety, autistic disorder, unspecified intellectual disability, bipolar disorder, and pseudobulbar affect. Resident #15's Admission MDS dated [DATE] revealed the resident was admitted to the facility with the diagnoses of non-Alzheimer dementia, seizure disorder, anxiety, depression, and bipolar disorder. The MDS noted the resident was on antipsychotic, antianxiety and antidepressant medications. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of resident #15's medical record revealed a care plan initiated on 9/16/20 noted the resident was at risk for communication problem due to difficulty making needs known, difficulty understanding related to (r/t) diagnosis of dementia, intellectual disabilities, autism and cognitive communication deficit. He also had a care plan for impaired cognitive function/dementia or impaired thought process r/t bipolar disorder, dementia, autism and unspecified intellectual disorder which was initiated on 12/19/22. Resident #15's care plan also revealed a risk for harm, self-directed or other directed behavior potentially causing harm. The care plan noted he had a history of kicking the foot board and hitting his fist on the mattress and hitting arm on siderail which was initiated on 1/21/23. A focus initiated on 9/22/20 listed Resident 15's as having the potential to be verbally and physically aggressive, use racial slurs toward staff and other residents, tends to make unfounded accusations about staff and family, hits self at times, yells out in room and makes sexually inappropriate comments. One of the interventions for this behavior was one to one supervision. Resident #15's Order Summary Report showed the resident had an order for Quetiapine Fumarate 400 mg at bedtime for schizoaffective disorder dated 6/11/24, Quetiapine Fumarate 200 mg two times a day for schizoaffective disorder dated 7/28/24, Trazadone 100 mg three times a day for depression dated 10/09/23, and Ativan 0.5 mg at bedtime for anxiety dated 7/27/24. Review of resident #15's PASARR dated 1/22/20 noted the Section 1: PASARR Screen Decision-Marking to be partially blank and the sections A and B to be missing the listed mental illness and intellectual disorders. In interviews on 8/07/24 at 3:32 PM and on 8/08/24 at 11:21 AM, the Director of Nursing (DON) acknowledged resident #46 and resident #15's level I PASARRs were incorrect. She confirmed no updates had been made to them by the facility at that time, but confirmed the facility should have updated them due to inaccuracies. She revealed once they were updated resident #15 triggered the need for a Level 2 screening. 48878 3. Review of the medical record revealed resident #55 was admitted to the facility on [DATE] from the hospital. Her diagnoses included bipolar disorder, recurrent severe major depressive disorder, and paraplegia. Resident #55's Admission Minimum Data Set (MDS) with an assessment reference date of 6/27/24 revealed the resident was admitted to the facility with the diagnoses of bipolar disorder and depression. The MDS noted the resident's high-risk drug class medications included antidepression medication. The admission assessment also noted the resident scored 15 out of 15 on the Brief Interview for Mental Status that indicated she did not have any cognitive impairment. Review of resident #55's medical record revealed a care plan initiated on 6/24/24 noted the resident was at risk for alterations in comfort related to bipolar disorder and depression. Resident #55's Order Summary Report showed the resident had an order dated 6/22/24 for Fluoxetine HCl 40 milligrams (mg) one time a day for depression. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/07/24 at 3:32 PM, the Director of Nursing (DON) stated it was the DONs responsibility to review PASARRs on admission to ensure they were accurate and submitted timely. The DON stated resident #55 was admitted on [DATE] with a diagnosis that included bipolar and major depressive disorder. She confirmed resident #55's PASARR Level I dated 12/28/22 did not list the diagnoses of bipolar and major depressive disorder which she was admitted with. She acknowledged a new PASARR should have been resubmitted since the level I was not accurate. The facility's Resident Assessment-Coordination with PASARR Program with revision date 9/18/23 read, This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability or a related condition receives care and services in the most integrated setting appropriate to their needs .PASARR Level I initial pre-screening that is completed prior to admission .The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission

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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** 35086 Based on observation, interview, and record review, the facility failed to follow accepted standards of practice to prevent cross-contamination during wound care for 1 of 2 residents reviewed for pressure ulcers, of a total sample of 38 residents, (#350). Findings: Resident #350 was admitted to the facility on [DATE] from an acute care hospital. Her diagnoses included dementia, seizures, hypertension, heart failure, acute kidney failure, unstageable pressure ulcer sacral wound and urinary tract infection. Review of the wound care physician orders dated 8/03/24 included daily treatment of the resident's sacrum. The order directed the nurses to cleanse with wound cleanser, pat dry, apply Santyl, super absorbency and cover with border foam. As defined by Centers for Medicare and Medicaid Services (CMS), Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar [i.e. dry, adherent, intact without erythema or fluctuance] . (Retrieved from the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Rev. 211, 02-03-23). Review of resident #350's medical record revealed a baseline care plan initiated on 8/02/24 for impaired skin integrity due to sacral pressure ulcer. The goal was the wound would show evidence of healing and be free from infection. The approaches included provide incontinence care as needed, provide treatment as ordered by physician, and weekly and as needed skin evaluations. Review of the most recent wound care note documented by the Advanced Practice Registered Nurse (APRN) dated 8/07/24, showed the resident had an unstageable pressure wound present since admission measuring 10.5 centimeters (cm) by 11.5 cm by 0.3 cm deep. The wound was noted with 20% granulation tissue, 80% eschar and exposed subcutaneous (fat) tissue with heavy purulent malodorous drainage. On 8/07/24 at 2:40 PM, prior to observation of resident #350's wound care, the North Wing Unit Manager (UM) was observed placing all treatment supplies (Santyl ointment in small plastic medicine cup, wound cleanser, border foam, tongue blade, super absorbency sponge and non-sterile gauze) on the residents' bedside table and did not clean, sanitize or place barrier drape on the table prior. Certified Nursing Assistant (CNA) A assisted with positioning the resident onto her left side during the wound care procedure. The UM performed hand hygiene, donned clean gloves and proceeded to do the wound care. She removed the soiled dressing from the resident's sacral/buttock region revealing a wound that presented as per the APRN's note dated 8/07/24. After removing the soiled dressing, the UM failed to perform hand hygiene before she donned the gloves to continue wound care and apply the new dressing as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/07/24 at 3:05 PM, after the wound care was completed the North Wing UM could not answer why she did not set up a clean field to place the wound dressing supplies nor why she did not wash her hands after removing the soiled dressing/gloves prior to applying the new dressing. She acknowledged she did not know the facility's policy and procedures. On 8/08/24 at 3:41 PM, the Director of Nursing (DON) and Regional Nurse expressed concern when informed of the break in infection control twice during resident #350's sacral wound care by the North Wing UM. The DON confirmed the North Wing UM should have sanitized the table in the resident's room before placing the dressing supplies on some type of barrier. The DON also confirmed the UM should have performed hand hygiene after removing the soiled dressings and before applying a new pair of clean gloves and the clean dressing to resident #350 to help reduce the spread of infection. The DON explained the UM was a new nurse to the facility, and said they needed to do further education with her regarding the wound dressing change process. Review of the facility policy and procedure for Clean Dressing Change revised 11/23/23 read, It is a policy of this facility to provide wound care in a manner to decrease potential for infection and/or cross contamination Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application: a. If the table is soiled, wipe clean. B. Place a disposable cloth or linen saver on the overbed table. c. Place only the supplies to be used per wound on the clean field . A review of the facility's policy and procedure for Hand Hygiene, revised on 5/21/22, read Staff will perform proper hand hygiene procedures to prevent the spread of infection . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .