

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Sunrise Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4800 N Nob Hill Rd Sunrise, FL 33351	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. This was observed during 2 of 2 visits conducted in the Main Kitchen. The findings included: On 02/23/26 at 8:47 AM, a tour of the facility's kitchen was conducted. Upon entering the kitchen, several male staff were observed with facial hair, none of which were wearing beard covers (Staff V, W, X, Y). Once the staff were alerted by the surveyor, Staff X donned a beard cover but did not cover his mustache. The surveyor had to explain to all the male staff that beard covers were to cover all facial hair, not just beards. The following was also observed: a. Two plates in the plate warmer were found to have food particles and the food contact surface of the plates showed signs of wear and excessive use. b. Two 50-ounce cans of Tomato Soup were noted with dents on the bottom of the cans in the dry stock room. c. The dishwashing machine was a high temperature model. During the observation, it was run 3 times, but it did not meet the required temperatures. The rinse cycle reached 175 degrees Fahrenheit, not the required temperature of 180 degrees. The wash cycle reached 125 degrees Fahrenheit and was also below the requirement of 150-165 degrees. Without reaching the proper temperatures, the dishes were not properly sanitized. In an interview conducted on 02/26/26 at 3:30 PM with the Administrator, she was informed of the findings.		

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 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** Based on observation, interview and record review, the facility failed to correctly complete Minimum Data Set (MDS) assessments for 2 of 35 sampled residents, Resident #54 and Resident #98. The findings included: 1. Record review revealed Resident #54 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction, Type 2 Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], under Section C revealed a Brief Interview of Mental Status (BIMS) score of 11 indicating the resident had moderate cognitive impairment. Section P-Restraints and Alarms of the same MDS revealed the MDS was coded as the resident using Bed Rails. An interview was conducted with Staff B, Licensed Practical Nurse (LPN), MDS Coordinator on 02/24/26 at 10:56 AM. She stated it was an error as they do not use restraints. 2. Record review revealed Resident #98 was admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Left Non-Dominant Side, Acquired Absence of Left Leg Above Knee, Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Record review of the quarterly MDS assessment dated [DATE] under Section C revealed the resident had a BIMS score of 6 indicating the resident had severe cognitive impairment. Section K of the same MDS revealed the MDS was coded as receiving intravenous (IV) fluids during the 7-day lookback period. In an interview with Staff B, LPN, on 02/24/26 at 10:56 AM, she stated hydration was triggered because the MDS was coded as the resident receiving IV fluids, but she did not have during that look back period.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide splints / protectors to assist in preventing contractures for 1 of 3 sampled residents reviewed for position and mobility, Resident #15. The findings included: Record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses of dementia, depression, and right-hand contracture. The [NAME] Data Set (MDS) dated [DATE] showed Resident #15's cognitive status to be severely impaired. A review of the physician's orders showed a Bilateral hand palm protector order every shift for skin integrity, dated 12/17/25. Review of the care plan dated 01/16/26 revealed contracture prevention and management, including split-type palm protectors for bilateral hands, refer to therapy as needed, and apply splints and remove them as scheduled. Review of the Occupational Therapy Evaluation and plan of treatment dated 12/12/25 revealed Resident #15 presents with Bilateral upper extremity hand contractures and recommended the use of splints in place. In an observation conducted on 02/24/26 at 10:20 AM, Resident #15 was noted in bed with no bilateral palm hand protectors on each hand. Resident #15's hands were noted to be very contracted. Closer observation revealed the palm protectors were located in Resident #15's top drawer of her dresser. No staff were noted at the time of this observation. In an observation conducted on 02/24/26 at 10:50 AM, Resident #15 was noted in bed with no bilateral palm hand protectors on each hand. Closer observation revealed the palm protectors were in Resident #15's top drawer of her dresser. No staff were noted at the time of this observation. In an observation conducted on 02/24/26 at 12:05 PM, Resident #15 was noted in bed with no bilateral palm protectors on each hand. Closer observation revealed the palm protectors in Resident #15's top drawer of her dresser. No staff were noted at the time of this observation. In an observation conducted on 02/24/26 at 12:50 PM, Resident #15 was noted in bed with no bilateral palm hand protectors on each hand. Closer observation revealed the palm protectors in Resident #15's top drawer of her dresser. No staff were noted at the time of this observation. In an interview conducted on 02/24/26 at 2:45 PM with the Assistant Director of Rehab, she stated Resident #15 has an order for bilateral palm protectors to help prevent pain and skin breakdown. It is the daily staff who are responsible for placing the splints on the residents, and they conduct audit visits to ensure that other staff members place them. In an interview conducted on 02/24/26 at 3:08 PM with Staff H, Certified Nursing Assistant / CNA, who has been working in the facility for the last 33 years, she stated that Rehab or she is responsible for placing the palm protectors on Resident #15. She further said that the palm protectors are on Resident #15 all the time and, when asked whether they were on today, said no.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to address weight loss in a timely manner and provide nutritional interventions for 3 of 5 sampled residents reviewed for nutrition, Resident #193, Resident #7, and Resident #59. The findings included: 1. Record review showed Resident #193 was admitted to the facility on [DATE] with diagnoses of Anemia and Depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #193 has a Brief Interview of Mental Status (BIMS) score of 08, indicating moderate cognitive impairment. In an interview conducted on 02/24/26 at 9:10 AM with Resident #193, he stated that he was in so much pain and could not eat his breakfast. Closer observation showed that the breakfast meal was untouched. In an interview conducted on 02/24/26 at 11:39 AM, Resident #193 was in the room with his lunch, consisting of marinated pork cubes, fluffy rice, carrots, and vanilla ice cream. Resident #193 stated that he is not very hungry, but he loves ice cream and would eat it on his tray. He further said that he would drink shakes if they were offered to him. Review of the Weights Log for Resident #193 revealed the following: 02/13/2026, a weight of 130.2 pounds. 02/12/2026, a weight of 130.2 pounds. 02/6/2026, a weight of 130.4 pounds. 01/12/2026, a weight of 142.0 pounds. 12/29/2025, a weight of 142. 0 pounds. 12/4/2025, a weight of 144.6 pounds. This showed a weight decrease noted from 01/12/26 to 02/6/26, going from 142 pounds to 130.4 pounds in one month, which was 8.1% weight loss. A nutrition assessment dated [DATE], 10 days later, noted the following: Resident #193 had 8.5% weight loss in 30 days, 50% of tray consumed, and presented with significant weight loss. In this assessment, a house supplement of 120 milliliters (ml) was recommended twice a day. Review of the physician's orders dated 02/17/26 showed an order for house nutritional supplements, 120 ml, two times a week for nutritional support, with a record amount consumed. Further review of the Medication Administration Record (MAR) revealed the House Supplements were never given to (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #193, nor was the amount consumed documented. Review of the care plan dated 02/09/26 revealed Resident #193 had significant weight loss expected related to poor intake, as evidenced by the use of an appetite stimulant; and Resident #193 will maintain adequate nutritional status as evidenced by maintaining weight, no signs and symptoms of malnutrition, and consuming at least 75% of at least 2 meals daily through the review date. In an interview conducted on 02/24/26 at 12:45 PM, Staff A, Unit Manager, stated that a house nutritional supplement is a Med Pass provided to residents by nursing and documented in the MAR. In an interview conducted on 02/25/26 at 9:26 AM, Staff K, Registered Nurse, stated that when an order is written for house supplements, he will provide "Med Pass and document in the MAR as given. When asked if Resident #193 was receiving house supplements, he said no. He checked the electronic system to verify the order and acknowledged that there was no record of a house supplement. In an interview conducted on 02/25/26 at 9:51 AM with Staff M, Registered Dietitian, he stated that a significant weight change is defined as a 5% change in one month. As soon as the weight loss is identified, the Dietitians will write an order for nutritional supplements if feasible. The Med Pass is calorie-dense and considered a good nutritional supplement, widely accepted. When entering the order for house supplements in the electronic system, the staff member must ensure the order type is changed to reflect the MAR. 2. Record review for Resident #7 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Cirrhosis of Liver, Protein-Calorie Malnutrition, Pressure Ulcer, Muscle Wasting and Atrophy, End Stage Renal Disease on Dialysis, Ascites, and Fluid Overload. Review of the 5 Day Minimum Data Set (MDS) for Resident #7 dated 02/24/26 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident had moderate cognitive impairment. Review of the physician's orders revealed a Fluid Restriction order dated 02/20/26 which included: 7:00-3:00 PM: 240 mL Juven (+30 mL Liquid Protein), 140 mL water 3:00-11:00 PM: 240 mL Juven (+30 mL Liquid Protein), 180 mL water 11:00 PM-7:00 AM 110 mL water (at bedside). On 02/26/26 the Physician's Orders for Resident #7 did not include any orders for nutritional supplements. Review of the care plan for Resident #7 dated 01/09/26 with a focus on Nutrition included interventions that the Registered Dietitian (RD) evaluated and made diet change recommendations and the facility provided supplements as ordered. Review of a Nutrition note dated 02/20/26 stated the resident agreed to Juven and liquid protein. Review of the readmission assessment dated [DATE] documented the resident was willing to try a Vanilla Flavored Magic Cup; Recommend Magic Cup daily (qd). (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/26 at 10:48 AM, an interview was conducted with Resident #7 who recalled he had tried a magic cup once and thought it was ok. He stated he did not receive it again. He also denied ever receiving or trying Juven. He expressed concern over his weight because he was eating well and still losing weight. On 02/26/26 at 12:37 PM, Staff M, RD, who had been employed by the facility for 2.5 years, stated the Magic Cup was ordered by a temporary RD and was unable to explain what happened to the order. On 02/26/26 at 1:15 PM, the Dietetic Technician, who had been employed by the facility for 8 months, was interviewed. She stated Resident #7 was prescribed a generic wound supplement packet since Juven was not available. The resident went to hospital and upon return, it was not restarted although his Fluid Restriction included the supplement. She stated it was an oversight. She confirmed the Magic Cup was ordered for one time only and was never followed up by the RD who ordered it to determine if the resident wanted it daily. 2. Record review for Resident #59 revealed the resident was admitted to the facility on [DATE]. The following diagnoses were included: Diabetes, End Stage Renal Disease on Dialysis, and Protein-Calorie Malnutrition. Review of the admission MDS for Resident #59 dated 02/01/26 revealed the resident had a BIMS score of 10, indicating the resident had moderate cognitive impairment. Resident #59 had a care plan dated 01/28/67 that focused on Nutrition which had a goal stating the resident would have gradual weight loss. Significant weight loss is 5% or more during a 30-day period. Review of Resident #59's weights reflected a significant weight loss of 15.9 pounds (lbs), 7.2% in 16 days (01/28/26 &dash; 02/13/26) and 20.3 lbs, 9.2% in 21 days (01/28/26 &dash; 02/18/26). Review of the Nutrition admission assessment dated [DATE] stated the goal was for gradual weight loss and the RD was to monitor dry weight. The last nutrition note as of 02/25/26, was dated 02/16/26, and the RD addressed other issues but there was no documentation regarding the resident's significant weight loss. On 02/25/26 at 10:04 AM, an interview was conducted with Staff M, RD. He stated residents on dialysis are initially assessed upon admission and then monthly or as needed. The documentation was in the progress notes. Staff M stated Dietary Staff usually have weights the same day they are taken thus a significant weight loss is addressed within a day or two and the system would provide an alert as well. The weights and dietary notes were reviewed with Staff M, and he acknowledged there was no documentation of the significant weight loss.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policy and procedure, observation, record review and interview, the facility failed to provide care and services and change the dressings for residents' Midline Intravenous (IV) catheter dressing in a timely manner, for 1 of 1 sampled resident observed, on the Locked Memory Care, G-wing, with a Midline catheter in place, Resident #23. The findings included: Review of the facility policy title, Midline Dressing Change, provided by the Director of Nursing (DON), revised on 01/2026 documented in the Policy Statement: It is the policy of this facility to change Midline dressing weekly, or if soiled, in a manner to decrease potential for infection and/or cross-contamination. Physician's orders will specify type of dressing and frequency of changes. Policy Explanation and Compliance Guidelines: g. Open sterile dressing kit. 6. Inspect the catheter-skin junction and surrounding area, palpating through the intact dressing for redness, tenderness, swelling and drainage. Be attentive to any reports of pain, paresthesia's, numbness, or tingling. 7. Remove old dressing beginning at the device hub and gently pull the dressing perpendicular to the skin toward the insertion site. 14. Clean the insertion site with an antiseptic following manufacturer's instructions. 16. If applicable, apply skin barrier solution and follow manufacturer's directions for use. 17. Secure the catheter with an engineered stabilization device, if available. 18. Apply a transparent semipermeable dressing to the insertion site. 21. Label the dressing with the date and time and your initials. 24. Document the procedure. Record review revealed Resident #23 was admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with diagnoses that included Atherosclerotic Heart Disease, Systolic (Congestive) Heart Failure, Essential (Primary) Hypertension, Adult Failure to Thrive, Chronic Kidney Disease, Chronic Pulmonary Edema, Acute and Chronic Respiratory Failure with Hypoxia, Chronic Obstructive Pulmonary Disease (COPD) with (Acute) Exacerbation and Parkinson's Disease with Dyskinesia, with Fluctuations. The record documented a Brief Interview Mental Status (BIMS) score of 9, indicative of moderate cognitive impairment. On 02/18/26, the physician's order documented, Midline Intravenous (IV): Change Transparent Dressing Weekly on every night shift every Monday and as often as needed (PRN). Record review of Resident #23's IV Medications care plan initiated 01/26/26 and revised 02/19/26 indicated Focus: Related to Pneumonia and Sepsis. Interventions: Administer IV medications as ordered. IV dressing: Transparent dressing. Observe dressing (PRN). Change dressing and record observations of site (as scheduled and PRN). Monitor/document/report PRN signs and symptoms of infection at the site: Drainage, inflammation, swelling, redness, warmth. Monitor/document/report PRN signs/symptoms of leaking at the IV site: Edema at the insertion site, taut, shiny or stretched skin, whitening/blanching or coolness of the skin, slowing or stopping of the infusion, leaking of I.V. fluid out of the insertion site. Goal: The resident will not have any complications related to IV Therapy through the review date. Record review of Resident #23's Antibiotic Therapy Care plan initiated 01/26/26 and revised 02/19/26 indicated Focus: .Related to Pneumonia and Sepsis. Interventions: Administer medication as ordered Goal: Manage symptoms without complications and will have current infection treated. On 02/23/26 at 1:05 PM, observation of Resident #23 in the Locked Memory Care Unit G-wing, revealed his Midline Intravenous (IV) was dated on the outside of the transparent IV dressing as: Wednesday 02/11 @ 9 AM. The dressing was observed with a small amount of old, dried blood noted in the base of the tubing. On 02/23/26 at 4:21 PM, during a second observation, Resident #23 was observed with his Midline Intravenous (IV) dated on the outside of the transparent IV dressing as: Wednesday 02/11 @ 9 AM. The dressing was observed with a small amount of old, dried blood noted in the base of the tubing. Record review of the (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Administration Record (MAR) documented that Resident #23 had been ordered the following three (3) IV medications: 1) Anti-fungal - Mycamine Intravenous Solution Reconstituted 100 mg (Micafungin Sodium) Use 100 mg intravenously one time a day for sepsis/Pneumonia. 2) Antibiotic - Vancomycin Hydrochloride (HCl) Intravenous Solution (Vancomycin HCl) initially 1250 mg intravenously one time a day for Methicillin Resistant Staphylococcus Aureus (MRSA). Subsequently, Vancomycin HCl Intravenous Solution (Vancomycin HCl) 750 mg intravenously in the morning for Sepsis. And 3) Antibiotic -Cefepime HCl Intravenous Solution Reconstituted 2 GM (Cefepime HCl) two (2) gram intravenously every twelve (12) hours for Complicated Urinary Tract Infection (UTI).Record review of the facility's nursing progress note dated 02/11/26 revealed that, Midline re-inserted to left upper arm, by IV access. IV line in place patent, flushed as indicated.Review of the nursing progress note dated 02/14/26 documented, .patient reported. having chest pain. 911 called, patient was assisted out of facility via stretcher transported to [hospital name] .admitted with diagnosis of Sepsis, Pneumonia and COPD exacerbation.Record review of the February 2026, 3008 Transfer Form documented Resident #23 had been returned to the facility from the hospital, with his original Midline IV catheter site and dressing to his left arm in place, for Antibiotic infusions.On 02/19/26, the progress notes documented, Resident is re-admitted to facility, with diagnosis of Sepsis, Methicillin Resistant Staphylococcus Aureus (MRSA), Complicated Urinary Tract Infection (UTI). Patient is.be continued on IV antibiotic.Further record review of Resident #23's MAR, the nurses' progress notes and of the Treatment Administration Record (TAR), did not show, nor document whether or not the Resident #23's original Midline IV transparent dressing had been changed since Wednesday 02/11 @ 9 AM; remaining in place for thirteen (13) days, after the original re-insertion date in the facility. An interview was conducted on 02/24/26 at 11:28 AM with Staff E, Licensed Practical Nurse (LPN), regarding Resident #23's outdated Midline IV transparency dressing site, in which she acknowledged that the resident had a Midline IV re-inserted on 02/11/26, by an outside company. Staff E acknowledged the resident had been transferred out of the facility on Saturday 02/14/26 on day shift to the hospital for Chest Pain, and was re-admitted last week on Wednesday 02/18/26, with the same Midline IV transparent dressing still remaining in place and not changed, until 02/23/26, the first day of survey after surveyor intervention.A side-by-side record review and interview was conducted on 02/24/26 at 11:38 AM with Staff Q, Registered Nurse (RN)/Unit Manager of the G-wing, regarding Resident #23's outdated Midline IV transparency dressing site, in which she acknowledged the resident had a Midline IV re-inserted on 02/11/26 by an outside company. She acknowledged the resident had been transferred out of the facility on Saturday 02/14/26 on day shift to the hospital, and was re-admitted on Wednesday 02/18/26, with the same Midline IV transparent dressing remaining in place and not changed until 02/23/26, the first day of this survey after surveyor intervention.The Director Of Nursing acknowledged on 02/24/26 at 4:30 PM that Resident #23's Midline IV transparent dressing should have been changed in a timely manner, and according to the physician's written orders.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and policy review, the facility failed to follow physicians' oxygen orders for 4 of 5 sampled residents reviewed for oxygen therapy and has the potential to affect 49 residents on oxygen therapy, Resident #38, Resident #229, Resident #108, Resident #228; failed to obtain physicians order for oxygen therapy administration for 1 of 5 sampled residents reviewed for oxygen therapy, Resident #49; and failed to follow the professional standards of practice during medication administration via an oral inhalation for 1 of 8 sampled residents for medication administration observation, Resident #54. The findings included: Review of the facility policy titled, Oxygen Therapy, provided by the Director of Nursing (DON) revised in 01/26, documented in the Policy Statement: To administer Oxygen when insufficient Oxygen is carried by the blood to the tissue. Procedure: Place signs Oxygen in use and No Smoking signs outside room. Adjust rate of flow according to doctor's orders. Record oxygen therapy on treatment record; time, rate of flow concentration, tolerance. 1. Record review showed Resident #38 was admitted on [DATE] with diagnosis of critical illness Myopathy and Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation. Review of the Medicare 5-Day Minimum Data Set (MDS) assessment dated [DATE] revealed that the Brief Interview of Mental Status (BIMS) score is 14, which indicates no cognitive impairment. A review of section O (Special treatments, Procedures and Programs) of the MDS indicated that Resident #38 was admitted with oxygen therapy to the facility. Review of the Physician's Orders indicated that on 01/06/26 an order for an oxygen concentrator with humidifier was placed for 2 liters per minute. Review of the care plan dated 01/08/26 documented Resident #38 has altered respiratory status and difficulty breathing. Goals are to maintain normal breathing pattern and have no complications related to shortness of breath. The interventions included setting oxygen with humidifier via nasal cannula at 2 liters as ordered. In an observation conducted on 02/23/26 at 10:45 AM, Resident #38 was seen lying in bed with the oxygen in placed and functioning. The oxygen was set at 1.5 liter per minute. In an observation conducted on 02/23/26 at 3:25 PM, Resident #38 was seen lying in bed with oxygen functioning at 1.5 liter per minute. 2. Record review showed that Resident #229 was admitted on [DATE] and readmitted [DATE] on with diagnosis of Pulmonary Candidiasis and COPD with acute exacerbation. Review of the Medicare 5-Day MDS assessment dated [DATE] revealed a BIMS score of 15, indicating no cognitive impairment. Review of section O (Special treatments, Procedures and Programs) of the MDS indicated Resident #229 was admitted with oxygen therapy to the facility. Review of the Physician's Orders indicated that on 02/11/26 an order for supplemental oxygen concentrator with humidifier was placed for 3 liters per minute. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 02/23/26 documented Resident #229 has altered respiratory status and difficulty breathing. Goal is to maintain normal breathing pattern. The interventions included setting oxygen with humidifier via nasal cannula at 3 liters as ordered. In an observation conducted on 02/24/26 at 12:09 PM, Resident #229 was seen seating on a wheelchair in her room with oxygen functioning at 2.5 liters per minute. In an interview conducted on 02/24/26 at 12:10 PM, Resident #229 stated that her oxygen is always set at 2 liters per minute. 3. Record review documented Resident #108 was admitted on [DATE] with diagnosis of Respiratory Failure with hypoxia and other sequelae of other cerebrovascular disease. The Medicare 5-Day MDS assessment dated [DATE] revealed a BIMS score of 00 indicating severe cognitive impairment. Review of section O (Special treatments, Procedures and Programs) of the MDS indicated Resident #229 started receiving oxygen therapy while being a resident in the facility. Review of the Physician's Orders indicated that on 02/24/26 an order for oxygen concentrator with humidifier was placed in for 2 liters per minute. Review of the care plan dated 01/29/26 documented Resident #108 has altered respiratory status and difficulty breathing. Goals are to maintain normal breathing pattern and have no complications related to shortness of breath. The interventions included setting oxygen with humidifier via nasal cannula at 2 liters as ordered. In an observation conducted on 02/23/26 at 12:35 PM, Resident #108 was seen lying in bed, sleeping with the bed placed in a low position and fall mattresses placed on each side of bed. Resident #108 was receiving 3 liters per minute of oxygen. In an observation conducted on 02/23/26 at 3:30 PM, Resident #108 was seen lying in bed, sleeping and receiving 3 liters per minute of oxygen. In an interview conducted on 02/26/26 at 11:00 AM, the Infection Control Preventionist stated that he has been working for the facility for about 2 years. He stated the staff were educated on oxygen and that they should always follow the order. He stated when setting the oxygen machine, it should be to eye level to put the right amount of liter. In an interview conducted on 02/26/26 at 11:15 AM with Registered Nurse (RN), Staff T, the nurse stated she has been working for the facility for about 2 years now. She stated you would go to the computer to check the order the oxygen should be on; then you go to the room at eye level and position it the ball of the machine on the line of the liters were supposed to be. She was made aware of the findings. In an interview conducted on 02/26/26 at 11:20 AM with Registered Nurse (RN) Unit Manager, Staff U stated he has been working in the facility for 1 year. He further stated the residents that come from the hospital come with their orders but residents that have a change in condition in the facility are (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seen by the doctor and reevaluate the resident. Staff U explained that he always checks the oxygen machines at eye level during his rounds, but the issue is that the unit is short-term, which means that the resident is manipulated by staff from different departments and the oxygen is constantly changed. 4. Record review for Resident #228 revealed the resident was admitted to the facility on [DATE]. Resident #228's diagnoses upon admission included: COPD, Respiratory disorders, Immunodeficiency, Obstructive sleep apnea, Acute maxillary sinusitis, Atherosclerotic heart disease, Dementia, Shortness of breath, and Atrial fibrillation. Review of Resident #228's physician orders included: Oxygen/concentrator with humidifier at 3 Liters per minute (LPM) via nasal cannula - every shift for shortness of breath & 02/24/26 Review of Resident #228's care plan for altered respiratory status documented: Resident has altered respiratory status/difficulty breathing r/t [related to] COPD, Respiratory disorder, SOB [shortness of breath], Obstructive Sleep Apnea, Pleural effusion, Atelectasis; Date Initiated: 02/24/2026, Revision on: 02/24/2026. The goal of the care plan was documented as: The resident will have no complications related to SOB through the review date. Date Initiated: 02/24/2026 Target Date: 05/21/2026. Interventions to the care plan included: OXYGEN SETTINGS: O2 with humidifier via (nasal cannula) (3)L as ordered Date Initiated: 02/24/2026. Review of the Plan of Care Note dated 02/24/26, documented: Note Text: Resident was admitted with diagnoses of polyneuropathy, psoriatic arthritis mutilans, chronic obstructive pulmonary disease (COPD), respiratory disorder, pleural effusion, immunodeficiency, and protein-calorie malnutrition. During assessment, he was noted to experience shortness of breath (SOB) when lying flat. The head of the bed is maintained in an elevated position to promote comfort and ease breathing. Respiratory status is being closely monitored due to underlying COPD. Oxygen therapy is administered as ordered, and nebulizer treatments are provided per orders. Physical and occupational therapy are actively involved to support recovery, address weakness and functional limitations associated with polyneuropathy and chronic illness and improve overall functional independence. On 02/23/26 at 3:49 AM, Resident #228 was observed in bed and was receiving oxygen (O2) at 2 LPM via nasal canula from an oxygen concentrator. When asked Resident #228 voiced no shortness of breath and no concerns. On 02/25/2026 at 8:34 AM, Resident #228 was observed in bed and was receiving O2 at 2.5 LPM via nasal canula from a concentrator. Photographic Evidence Obtained. During an interview, on 02/25/26 at 2:49 PM, with Staff O, RN, when the RN was shown the photographic evidence of the oxygen concentrator being set at 2.0 and 2.5 LPM, the RN stated, sometimes when you are looking at it, it only looks like it is not at 3 LPM. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/2026 at 9:28 AM, Resident #228 was observed in bed receiving O2 at 2.5 LPM. During an interview, on 02/26/26 9:49 AM, with Staff P, RN, the RN confirmed the order for oxygen at 3 LPM. When the RN was shown the photographic evidence of the resident not receiving the O2 as ordered, the RN acknowledged that the findings were accurate. Staff P stated, sometimes he takes it off and we have to educate him on it. He will titrate it. I switched it back to 3. During an interview, on 02/26/26 at 11:11 AM, when asked about changing the settings on the concentrator, Resident #228 stated, I can't reach it and I don't touch it. 5. Record review revealed Resident #49 was admitted to the facility on [DATE] and he was readmitted to the facility on [DATE] with diagnoses which included Vascular Dementia, Atherosclerotic Heart Disease, and Epilepsy. The record documented a BIMS score of 3, indicative of severe cognitive impairment. During an observation conducted on 02/23/26 at 10:05 AM, Resident #49 was observed with Oxygen infusing at two (2) liters via Oxygen tank. There was no signage noted outside of the resident's doorway, signifying Oxygen Therapy in use. Record review of the Form 3008 Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form, dated 02/19/26, did not document Oxygen usage for this resident, prior to readmission to the facility, following an episode of Chest Pain. Record review of Resident #49's Oxygen Saturation Levels dating from Monday 02/16/26 until Monday 02/23/26 revealed that the range was 96-98%; either on room air (RA), or on Oxygen via nasal cannula. There were readings for Oxygen Therapy dating as far back as 01/15/26, with an Oxygen saturation level of 96% at two (2) liters via nasal cannula. Record review of 4 nursing facility progress notes dated from 02/20/26 through 02/23/26, revealed the following, with regards to the Resident #49's respiratory status, after readmission to the facility, .Resident returned to the facility from.Hospital. Respiration even and unlabored. No acute respiratory distress noted. Lungs clear throughout bilaterally. No difficulty breathing. No cough noted. Right lung clear. Left lung clear. No shortness of breath noted. Right lung clear. Left lung clear. Humidification: Yes. Oxygen via nasal cannula. Further record review revealed there was no physician's order in place for Oxygen Therapy Administration for Resident #49. Record review of the Resident #49's Respiratory care plan initiated 01/19/26 and revised 01/19/26 indicated: Focus: Resident has altered respiratory status/difficulty breathing related to Shortness of Breath and Cough. Interventions: Administer medication as ordered.Monitor for s/sx of respiratory distress and report to MD PRN: Increased Respirations; Decreased Pulse oximetry; Increased heart rate (Tachycardia); Restlessness; Diaphoresis; Headaches; Lethargy; Confusion; Hemoptysis; Cough; Pleuritic pain; Accessory muscle usage; Skin color changes to blue/grey. Monitor/document/report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea, prolonged (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inhalation, prolonged exhalation, prolonged shallow breathing, prolonged deep breathing, use of accessory muscles, pursed-lip breathing, nasal flaring. Goal: The resident will have no complications related to shortness of breath through the review date. An interview was conducted on 02/23/26 at 1:31 PM with Staff R, Certified Nursing Assistant (CNA), regarding Resident #49's Oxygen use. Staff R revealed the resident had been on Oxygen since her first admission and the readmission to the facility. The CNA stated she had seen the resident on the Oxygen concentrator, when in bed and whenever the resident comes out of the room, she will use the Oxygen tank. An interview was conducted on 02/23/26 at 1:46 PM with Staff E, Licensed Practical Nurse (LPN), regarding Resident #49's Oxygen use. She acknowledged the resident had been having Oxygen infusing at two (2) liters since she was transferred to this unit from the E-wing, prior to February 2026. Staff E stated the resident had to be put back on continuous Oxygen, after she failed a trial without it. Staff E acknowledged there had been no physician's order for the Oxygen therapy in place. A side-by-side record review and interview was conducted on 02/23/26 at 1:56 PM with Staff Q, Registered Nurse (RN), Unit Manager, regarding the Resident# 49's Oxygen use. Staff Q acknowledged the resident had currently been on Oxygen at two (2) liters. Prior to her transfer to the G-wing Memory Care Unit, Staff Q stated Resident #49 had been on the E-wing and acknowledged there had never been a physician's order in place for Oxygen therapy, to include the liters and parameters for care. The Director of Nursing (DON) acknowledged on 02/23/26 at 4:30 PM that Resident #49 had been receiving Oxygen therapy for her entire facility stay, and a physician's order should have been obtained for its use. Review of the policy titled, Medication Administration, implemented on 02/01/23 and revised on 01/26, documented the following: To obtain and record vital signs, when applicable, or per physician orders. If other than per Orem (po) route, administer in accordance with facility policy for the relevant route of administration. Review of the policy titled, Nebulizer Therapy, implemented on 02/01/23, and revised on 02/26, documented the following: Obtain vital signs, and respiratory assessment to establish baseline. Disassemble and rinse the nebulizer with sterile or distilled water and allow air to dry. Records review documented Resident #54 was admitted to the facility on [DATE] with diagnoses that included Cerebral Infarction due to unspecified Occlusions or Stenosis of the Right Cerebellar Artery, Respiratory Disorders in Diseases Classified Elsewhere, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, and Chronic Respiratory Failure, Unspecified Whether Hypoxia or Hypercapnia. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] under Section C documented a Brief Interview for Mental Status (B IMS) score of 11 indicating Resident #54 had moderate cognitive impairment. Review of the physician order dated 07/30/25 documented for: Ipratropium-Albuterol Solution 0.5-2.5 (3 milligram[mg]/3 milliliter[m]), inhale orally four times a day for shortness of breath (SOB)/wheezing. Review of the documented vital signs including respiratory rate, blood pressure and oxygen saturation for Resident #54 revealed that they are usually taken during the 3 PM to 11 PM shift by Staff F, Licensed Practical Nurse (LPN). Review of the vital signs revealed no documentations after 02/24/26. The documentation below revealed no consistency in vital signs monitoring and recording. Below is the latest documentation of recorded respiratory rates: 02/24/2026 20:11 18 Breaths/min Staff F, LPN, (Manual) 02/17/2026 17:04 18 Breaths/min Staff F, LPN (Manual) 02/16/2026 17:07 18 Breaths/min Staff F, LPN (Manual) Below are the latest blood pressure readings: 02/24/26 20:11 135/63 mmHg lying l/arm Staff F, LPN 02/17/26 17:04 106/63 mmHg lying r/arm Staff F, LPN 02/16/26 17:07 122/74 mmHg sitting r/arm Staff F, LPN Below are the latest oxygen saturation readings: 02/24/26 20:11 97% oxygen via nasal cannula Staff F, LPN 02/21/26 01:47 97% oxygen via nasal cannula another Staff 02/17/26 17:04 94% oxygen via nasal cannula Staff F, LPN Review of recent nursing progress notes did not reveal any documentation of lung auscultations before and after oral inhalation therapy. There was no documentation of vital signs such as respiratory rate, heart rate, blood pressure and oxygen saturation before and after oral inhalation therapy for Resident #54. Review of Medication Administration Records (MAR) for 02/2026 revealed no documentation of vital signs before and after oral inhalation therapy for Resident #54. During a medication observation for an oral inhalation treatment on 02/24/26 at 4:35 PM for Resident #54, with Staff F, LPN, the following were observed: (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff F entered Resident #54's room on 02/24/26 at 4:40 PM, with the oral inhalation medication, disinfecting wipes, and a plastic cup with approximately 8 ounces water. Staff F did not bring the oximeter to check for oxygen saturation, a sphygmomanometer to check the blood pressure, and a stethoscope to check for lung sounds. Staff F placed the inhalation mask onto the resident's face. Staff F proceeded with providing the oral inhalation therapy without lung auscultation, and did not obtain the respiratory rate, blood pressure and oxygen saturation of Resident #54 on 02/24/26 at 4:43 PM. After the procedure on 02/24/26 at 4:56 PM, Staff F immediately left the room after hearing an interview with Resident #54's roommate asking her if staff checked her lung sounds before and after a nebulizing treatment. Staff F returned to the room on 02/24/26 at 4:58 PM with a stethoscope and an oximeter. He stated the oxygen saturation was 99% on 02/24/26 at 4:59 PM. He started auscultating for lung sounds after obtaining Resident #54's oxygen saturation level. When Staff F was asked if they check Resident #54's vital signs, and lung sounds before and after oral inhalation treatment, he responded, yes. He stated they record them in progress notes and in vital signs section on their computer. When asked if they record them somewhere else, he responded, no, only in those areas. When asked if they record the time when vital signs were checked, he responded yes. In an interview conducted with Staff D, LPN on 02/25/26 at 11:30 AM, when she was asked her process of providing oral inhalation treatment to a resident, stated the following: Assist the resident in sitting position; Check both lungs, upper and lower back, to ensure they are clear, using a stethoscope; Check the pulse oximeter for measurement of oxygen saturation; Explain to the patient what she is going to do; Put the mask on to the resident, ensure it is not too tight or lose; Start the treatment. Stay with the patient; When finished, remove the mask, ask if patient is ok; Check oximeter for oxygen saturation, and check the lung sounds, starting at the back. She then added that it is the end. In an interview conducted with Staff A, LPN on 02/26/26 at 8:48 AM, when she was asked her process when providing oral inhalation treatment for a resident responded: Identify herself to the resident and check the resident's identification wrist band; Check both lungs for lung sounds after explaining to resident what she is going to do; Put resident's mask on, check proper fit, and stay with the resident for 15 minutes or until the medication is completed; Listen again to lung sounds. Document in progress notes. Interviews with facility staff revealed they do not monitor respiratory rate before and after oral inhalation and nebulizing treatment. In an interview conducted with the Nurse Educator on 02/24/26 at 5:21 PM, when he was asked where they document vital signs before and after inhalation treatment, responded, in the progress notes and on the Medication Administration Record (MAR). During another interview with the Nurse Educator on 02/26/26 at 9:45 AM, he was informed that staff assess lung sounds but do not monitor respiratory rates before and after oral inhalation and nebulizing (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment as evidenced by no progress notes and no Medication Administration Record (MAR) documentations.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of facility policy, the facility failed to ensure communication sheets were filled out accurately and completely for 2 of 3 sampled residents reviewed for dialysis, Resident #59 and Resident 105. The findings included: Review of the policy, titled, Weight Monitoring, dated 09/01/22, documented, weights should be recorded at the time obtained. Review of the facility's contract with an outside dialysis company, effective 02/14/25, page 6, documented, communication between the Facility and the Dialysis Center was via a communication form that must contain the most recent vital signs and current weights. The Dialysis Center was to enter the total amount of fluid removed. Review of the communication form revealed a notation stating the floor nurse was to report post weight promptly to dialysis. 1. Record review revealed Resident #59 was admitted to the facility on [DATE]. The following diagnoses were included: Diabetes, End Stage Renal Disease on Dialysis, and Left Leg Below Knee Amputation. Review of the admission Minimum Data Set (MDS) for Resident #59 dated 02/01/26 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating the resident had moderate cognitive impairment. Review of the care plan for Resident #59 dated 01/28/26 with a focus on Dialysis had interventions stating to document vital signs before leaving and upon returning to the facility and to weigh before and after dialysis. On 02/24/26, review of Resident #59's weights revealed the following: -No pre weight entered on 02/04/26, 02/13/26, 02/16/26, 02/18/26, 02/20/26, and 02/23/26. -No post weight entered on 01/30/26, 02/06/26, 02/09/26, 02/11/26, 02/20/26, and 02/23/26. Review of Resident #59's dialysis communication forms for the months of January 2026, and February 2026 revealed the following: -No blood sugar results documented on 01/28/26, 01/30/26, 02/16/26, and 02/18/26. -No pre weights documented on 02/13/26 and 02/23/26. -No total fluids removed documented on 02/02/26 and 02/16/26. Further review of the dialysis communication sheets showed the following discrepancies between the weights and the amount of fluids removed: -On 02/06/26 - 12.1-kilogram (kg) weight difference per pre and post weights, 3.0 kg was documented. -On 02/04/26 - 3.8 kg weight difference per pre and post weights, 2.7 kg was documented. -On 02/11/26 - 4.4 kg weight difference per pre and post weights, 2.4 kg was documented. -On 02/16/26 - 12.8 kg weight difference per pre and post weights, amount of fluids removed was not documented. -On 02/25/26 - 4.2 kg weight gained per pre and post weights, 2.7 kg loss was documented. 2. Record review revealed Resident #105 was admitted to the facility on [DATE]. The following diagnoses were included: End Stage Renal Disease on Dialysis, Anorexia, and Protein-Calorie Malnutrition. Review of the 5 Day Minimum Data Set (MDS) assessment for Resident #105 dated 02/07/26 revealed the resident had a BIMS score of 13, indicating the resident had intact cognition. Review of the care plan for Resident #105 dated 01/16/26 with a focus on Dialysis had interventions stating to document vital signs before leaving and upon returning to the facility and to weigh before and after dialysis. On 02/24/26, a review of Resident #105's weights in the record revealed the following: -No pre weight entered on 01/19/26, 01/21/26, 02/02/26, 02/11/26, 02/13/26, 02/16/26, and 02/18/26. -No post weights entered on 01/30/26 and 02/06/26. Review of Resident #105's communication forms revealed the following: -No pre weights were documented on 01/19/26, 01/26/26, 01/30/26, 02/02/26, 02/04/26, 02/06/26, and 02/09/26. Discrepancies between weights and amount of fluid removed: -On 01/23/26 - 1.5 kg weight difference per pre and post weights, 0.8 kg was documented -On 01/28/26 - 2.5 kg gained per pre and post weights, 1.7 kg loss was documented. -On 02/18/26 - 1.6 kg weight difference per pre and post weights, 0.8 kg was (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented. On 02/25/26 at 10:26 AM, an interview was conducted with Staff Z, Registered Nurse (RN) and Unit Manager (UM), who had been employed by the facility for 23 years. She stated before and after dialysis weights were taken by the Certified Nursing Assistants (CNAs) who then provided the results to the nurses. The nurses entered them into the system the day the weights were taken. If there was a notable difference with the weights, they would notify the Registered Dietitian. Staff Z was then alerted to missing pre and post weights in the electronic health records of Residents #59 and #105. On 02/26/26 at 12:10 PM, an interview was conducted with Staff Z during which dialysis communication forms for Residents #59 and #105 were presented to her. She was alerted to the missing blood sugar results, pre weights, and post weights, as well as the discrepancies in fluid removal amounts. She acknowledged the missing documentation. On 02/26/26 at approximately 12:15 PM, an interview was conducted with Staff A, Licensed Practical Nurse (LPN) and UM, who confirmed the pre and post weights were taken at both the facility and dialysis center. Discrepancies were then communicated to the dialysis center and residents were reweighed. On 02/26/26 at 12:37 PM an interview was conducted with Staff M, Registered Dietitian (RD), who had been employed by the facility for 2.5 years. He stated when weights were entered into residents' records, it would alert him of significant weight changes and agreed that entering weights accurately and timely was important for him to do his job. On 02/26/26 at approximately 12:30 PM, an interview was conducted with Staff CC, CNA, who had been employed by the facility for 1 year. She stated she had residents who were on dialysis and she weighed them before and after treatment. She then passed the weight information to the nurse to input them into the records.		

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to document the code status in the physician's orders for 1 of 35 sampled residents, Resident #6. The findings included: Review of the facility's policy titled, Communication of Code Status, date implemented 4/2022 and date revised 1/2025, revealed When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical records. Examples of directions to be documented include, but are not limited to: a. Full Codeb. Do Not Resuscitatec. Do Not Intubated. Do Not HospitalizeThe designated sections of the medical record are: Order Section of Point Click Care.On 02/24/26 at 10:22 AM a review was conducted of the Physician Orders for Resident # 6. The orders did not reveal a code status order.On 02/25/26 at 9:50 AM an interview was conducted with Staff A, a Licensed Practical Nurse (LPN) and Unit Manager. She stated to find the code status they check the Electronic Health Record (EHR) and care plan. The code status should be in the Physician's Orders. If it is not in the Physician's Orders, they check the care plan. Record review reveled Resident #6 was admitted to the facility on [DATE] with diagnoses that included Type 2 Diabetes Mellitus, Other Idiopathic Peripheral Autonomic Neuropathy, and Peripheral Vascular Disease. Review of the quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 indicating the resident had intact cognition. On 02/24/26 at 10:22 AM, a review was conducted of the Physician Orders for Resident # 6. The orders did not reveal a code status order. On 02/25/26 at 9:50 AM, an interview was conducted with Staff A, Licensed Practical Nurse (LPN) and Unit Manager. She stated to find the code status they check the Electronic Health Record (EHR) and the care plan. The code status should be in the Physician's Orders. If it is not in the Physician's Orders, they check the care plan. The order was added after surveyor intervention.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Sunrise Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4800 N Nob Hill Rd Sunrise, FL 33351	
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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to maintain residents' call lights in a working manner for 2 of 35 residents in the final sample, Residents #112 and 225. The findings included: 1. Record review revealed that Resident #112 was admitted to the facility on [DATE]. According to the resident's most recent complete assessment, a Quarterly Minimum Data Set (MDS) with a reference date of 02/02/26, Resident #112 had a Brief Interview for Mental Status (BIMS) score of 09, indicating the resident was moderately cognitively impaired. The assessment documented that the resident required partial/moderate assistance for transfers and was able to walk short distances independently and up to 150 feet with assistance and was frequently incontinent of bowel and bladder. Resident #112's diagnoses at the time of the assessment included: Anemia, Hypertension, Heart failure, Renal insufficiency, DM, Hyperlipidemia, Hip fracture, Malnutrition, Chronic lung disease, refractory anemia, Pulmonary fibrosis, Immunodeficiency, Muscle wasting and atrophy, Muscle weakness, Dependence on renal dialysis, Adjustment disorder with depressed mood, Pleural effusion. Review of Resident #112's care plan for falls documented: Resident is at risk for falls r/t [related to] Gait/balance problems, Impaired mobility r/t left femur fx,[fracture] Thoracolumbar Spondylopathy and Disc degeneration Date Initiated: 10/29/2025 Revision on: 10/29/2025. The goal of the care plan was documented as: The resident will be free of falls through the review date. Date Initiated: 10/29/2025 Revision on: 11/10/2025 Target Date: 04/21/2026. Interventions in the care plan included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 10/29/2025; and The resident needs a safe environment with: (Such as: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; personal items within reach) Date Initiated: 10/29/2025. On 02/24/26 at 10:34 AM, the call light in the resident's bathroom was noted to be tied around the grab bar to the resident's right side of the commode. During an interview, on 02/26/26 at 9:38 AM, with the Activities Director, the Activities Director confirmed that Resident #112 was physically and mentally able to use the call light, we remind her to use it when she needs help. During an interview, on 02/26/2026 at 9:41 AM, with Staff N, Registered Nurse (RN)/Unit Manager, the RN confirmed that Resident #112 was physically and mentally able to use the call light. 2. Record review revealed that Resident #225 was admitted to the facility on [DATE]. According to the resident's baseline care plan, with a reference date of 02/23/26, Resident #225 was 'cognitively impaired' with confusion. The baseline care plan documented that the resident required limited assistance with bed mobility, transfers, locomotion and toileting. Review of Resident #225's care plan for Activities of Daily Living (ADLs) documented: Resident has an ADL self-care performance deficit related to Activity Intolerance, Limited Mobility, Musculoskeletal impairment, Sequelae of Cerebrovascular Accident (CVA), Cerebral ischemia Date Initiated: 02/23/2026 Revision on: 02/23/2026. Interventions to the care plan included: Encourage the resident to use bell to call for assistance. Date Initiated: 02/23/2026. Review of Resident #225's care plan for falls documented: Resident is at risk for falls related to Gait/balance problems, Impaired mobility, Sequelae of CVA, Cerebral ischemia, Muscle wasting and atrophy and End Stage Renal Disease (ESRD) Date Initiated: 02/23/2026 Revision on: 02/23/2026. Interventions to the care plan included: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Date Initiated: 02/23/2026 The resident needs a safe environment with: (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Sunrise Health & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4800 N Nob Hill Rd Sunrise, FL 33351	
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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(Such as: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; personal items within reach) Date Initiated: 02/23/2026. On 02/24/26 at 9:01 AM, the call light in the resident's bathroom was noted to be tied around the grab bar to the resident's left side of the commode. On 02/26/2026 at 9:05 AM, the call light in the resident's bathroom was noted to be tied around the grab bar to the resident's left side of the commode. During an interview, on 02/26/26 at 9:43 AM, with Staff N, the RN stated, he can use the call light, but he can't use the bathroom by himself. He is 1 person assistance to the toilet. We tell him to use the call light. We check on him time to time before he finishes.		