STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165286	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Hill Care Center	909 6th Street Traer, IA 50675

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35438 Based on observation, clinical record review, staff and resident interviews, the facility failed to ensure that 1 of 3 residents reviewed were treated with dignity and respect (Resident #3). On 5/23/24 Staff A, Certified Nursing Assistant (CNA) yelled at Resident #3 in a disrespectful and undignified manner using foul language. The facility reported a census of 45 residents. Findings included The quarterly Minimum Data Set (MDS) dated [DATE] revealed short term memory problems and modified independence, some difficulty in making daily decisions in new situations only. The MDS further documented no behaviors or rejection of care and independent for chair to bed transfer and ability to stand from a seated position. The MDS further identified diagnoses that included: Malignant neoplasm of the right breast, chronic kidney disease, and Diabetes Mellitus. The Care Plan dated as initiated on 4/1/24 identified a focus are related to impaired cognitive function/dementia or impaired thought processes and directed staff to ask yes or no questions and cue resident and supervise as needed. Review of an Alleged Abuse Investigation of Resident #3 summary prepared and signed by the Director of Nursing (DON) included: On 5/28/24 Resident #3 reported to her daughter that last week a CNA had come into her room and told her it was time to go to bed. Resident #3 responded that it was too early. Resident #3 went to stand up and the CNA pushed her back down causing her knees to buckle and land on the floor beside her bed. Resident # 3 reported the CNA called her a derogatory name and also called her a princess. Resident #3 described the CNA and positive identification was made by showing a picture of Staff A, CNA to the resident. Resident #3 was checked for any skin markings that may have resulted from the incident and none were identified. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 7/16/24 at 1:45 p.m. Resident #3 was well groomed and sitting in her recliner in a private room. Stated that a staff person, described as a large gal with reddish hair, had pushed her on the chest causing her to fall from her bed to the floor. She was able to get back in bed, but wasn't ready to go to bed at that time. The staff person scared her and yelled at her using foul language and called her a derogatory name. Resident #3 added that she had reported to her daughter. Stated she was shown a picture and was able to identify the staff person who had yelled at her. Resident #3 responded that the staff person had not been back in her room since she reported her concerns, and that she feels safe at the facility but does not feel that she should be treated like that. In an interview on 7/16/24 at 4:09 p.m. Staff A, CNA identified that she had only had difficulty getting Resident #3 to bed on one occasion which was determined to be 5/23/24. Staff A stated she had first approached at 8:30 p.m. and Resident #3 had informed she was not ready to go to bed. Staff A stated she had re-approached at 9:00 p.m. and the resident allowed to toilet and get ready for bed in the bathroom, but wasn't happy about it. Staff A described that she had a gait belt on Resident #3 and walked her back to her bed, but again stated the resident was not happy and didn't want to go to bed. Staff A stated she lifted the bed so that Resident #3 could stand up easily and transferred her with the gait belt to her chair. Staff A denied pushing Resident #3 but did admit to calling her a derogatory name. Staff A stated she realized this was wrong. In an interview on 7/17/24 at 12:04 p.m. the daughter of Resident #3 stated that on 5/28/24 her mother told her that week prior an aide had wanted to put her to bed at 8:00 p.m., but her mom had informed the aide it was too early. Added that her mom reported that the aide had called her a derogatory name and a princess. The family member responded that her mother was calm, not crying or upset but was mad. Did say that her mother stated she had slept with one eye open, but really never brought it up again to her. Her mother had described the stature and hair color of the staff person and stated that she was in the room when her mother confirmed the staff person's identity by looking at a picture provided by the facility staff. In an interview on 7/16/24 at 2:10 p.m., the DON verified that she had completed the investigation The facility had suspended Staff A prior to her next shift. Prior to completion of the investigation Staff A had resigned however the facility had determined that Staff A had violated the abuse policy and that her language and treatment of Resident #3 was not the kind of treatment that is tolerated by the facility. Review of facility Abuse Prevention, Identification, Investigation and Reporting Policy dated as last reviewed 4/24 included: the expectation that all residents have the right to be from abuse. Definition of verbal abuse included: oral, written or gestured language that willfully include disparaging and derogatory terms to residents, or within their hearing distance.