

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335568	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/09/2024
NAME OF PROVIDER OR SUPPLIER  Sunrise Manor Ctr for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1325 Brentwood Road Bay Shore, NY 11706	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50951</p> <p>Based on observations, interviews, and record review during an abbreviated (NY00360500) survey conducted on 12/04/2024 through 12/09/2024, the facility failed to protect each resident's right to be free from sexual abuse. This was identified for one (Resident #1) of four residents reviewed for sexual abuse. Specifically, Resident #1, with a diagnosis of Dementia and severely impaired cognition, was observed in Resident #2's room by Licensed Practical Nurse #1 performing oral sex. Resident #2 was cognitively intact. Resident #1's family member was interviewed and stated that if Resident #1 was cognitively intact, they would have been upset, embarrassed, and humiliated. This resulted in actual psychosocial harm to Resident #1 and the potential for harm to 9 of 72 cognitively impaired residents reviewed for sexual abuse, which was Immediate Jeopardy and Substandard Quality of Care.</p> <p>The Findings Are:</p> <p>The facility policy titled, Abuse Prohibition and Prevention Policy, revised on 9/11/2024 documented, Definition of Criminal Sexual Abuse as including the resident lacks the ability to understand the nature of the sexual act.</p> <p>Resident #1, [AGE] years old admitted on [DATE] with diagnoses including vascular dementia and depression with a Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 7, which indicates severely impaired cognition. (The Brief Interview for Mental Status assessment uses a points system: 0 to 7 points suggests severe cognitive impairment, 8 to 12 points suggests moderate cognitive impairment, and 13 to 15 points suggests that cognition is intact.)</p> <p>Resident #2, [AGE] year-old admitted on [DATE] with diagnoses including right leg above knee amputee, coronary artery bypass graft and hypertension, had intact cognition with a Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental status score of 15.</p> <p>Nursing progress notes dated 11/13/2024 at 5:43 PM signed by the Director of Nursing documented they were informed on 11/13/2024 by Licensed Practical Nurse #1 that they witnessed an incident involving Resident #1 and Resident #2 engaging in a sexual activity. Resident #1 was assessed and was confused but alert. No bruising, pain or redness. Medical Doctor made aware and ordered Psychiatric consult. The note further documented that Resident #1 was transferred to a different unit for safety.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Nursing progress notes dated 11/13/2024 at 6:19 PM signed by the Director of Nursing documented they were informed on 11/13/2024 by Licensed Practical Nurse #1 that they witnessed an incident involving Resident #1 and Resident #2 engaging in a sexual activity. Resident #2's arms and legs were assessed no bruising redness or marks. Resident #2 refused assessment of their genitalia and abdomen. Medical Doctor made aware and ordered Psychiatric consult.</p> <p>Nursing Progress notes dated 11/13/2024 at 10:49 PM signed by Licensed Practical Nurse #1 documented they observed Resident #1 engaging in oral sex with Resident #2. Licensed Practical Nurse #1 removed Resident #1 from Resident #2's room and paged the Director of Nursing.</p> <p>VA Comprehensive Care Plan dated 11/13/2024 for Resident #2 documented risk for abuse with a long goal for no lasting effects from the event for 90 days.</p> <p>The Accident and Incident report dated 11/14/2024 documented Resident #1 as the alleged perpetrator, They (Resident #1) were having fun with a smile on their face. The incident was witnessed by a facility staff member (Licensed Practical Nurse #1). The incident report documented Resident #2 as the victim. Resident #2 stated it was consensual. The facility concluded no abuse, neglect or mistreatment occurred.</p> <p>A Comprehensive Care Plan dated 11/14/2024 for Resident #1 lacked documented interventions to prevent victimization. The comprehensive care plan did not address the witnessed sexual contact with Resident #2.</p> <p>A telehealth Psychiatric consult note dated 11/25/2024 at 3:48 PM documented Resident #1 could not recall the incident of the witnessed sexual activity. The note did not include any further psychiatric follow up or interventions.</p> <p>A Psychiatrist noted 11/25/2024 at 4:04 PM documented Resident #2 refused to be evaluated.</p> <p>During an observation on 12/04/2024 at 10:15 AM Resident #1 was observed in their wheelchair outside of the nurse's station. Resident #1 was unable to be interviewed due to their severely impaired cognition. Resident #2 was observed on their unit sitting in their wheelchair and refused to be interviewed.</p> <p>During an interview with Certified Nursing Assistant #1 on 12/04/2024 at 3:28 PM, they were assigned to Resident #1 on the day of the incident. They stated Resident #1 would circle the unit in their wheelchair but does not wander off the unit or into other resident's rooms.</p> <p>During a telephone Interview with the former Social Worker #1 on 12/06/2024 at 12:58 PM and 3:47 PM they stated they did the Brief Interview of Mental Status assessment for Resident #1 on 09/16/2024. They recall Resident #1 was confused at the time of the assessment. Social Worker #1 stated Resident #1 wandered around the unit but does not wander into other resident's room. Social Worker #1 further stated that based on their mental status assessment, Resident #1 does not have the capacity to give consent due to their severely impaired cognitive status.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with Licensed Practical Nurse #1 on 12/4/2024 at 3:02 PM, they stated during a medication pass they went into Resident #2's room and witnessed Resident #2 sitting in their wheelchair by the window side of their bed wearing shorts. The shorts were pulled up along their right leg with the amputation. Resident #2 was holding their genitals in their hand. Resident #1 was in their wheelchair and was performing oral sex on Resident #2. Licensed Practical Nurse #1 stated they immediately separated the residents and notified the Nurse Supervisor.</p> <p>During an interview with the Director of Nursing on 12/5/2024 at 1:38 PM they stated at the time of the incident on 11/13/2024 Resident #1 knew what they were doing because when they interviewed Resident #1, Resident #1 smiled and stated they were having fun. Resident #2 had the capacity to notify the nurse, but stated it was consensual. The Director of Nursing did not respond whether Resident #1 had the capacity to give consent.</p> <p>During an interview with the Administrator on 12/5/2024 at 4:37 PM, they stated they were aware of the incident involving Resident #1 and Resident #2. The Administrator further stated they believe the sexual act between the residents was consensual because Resident #1 stated they were having fun and was smiling. The Administrator stated they notified Local Law Enforcement as a method of precaution.</p> <p>During an interview with the Psychiatrist on 12/6/2024 at 7:11 PM they stated they saw Resident #1 about 2-3 times since their admission to the facility. They assessed Resident #1 a couple of days after the incident via Tele-Health, and Resident #1 was unable to recall the incident. The Psychiatrist stated staff should be monitoring Resident #1 for any negative effects. The Psychiatrist stated the incident should never have occurred, and all efforts should be made to prevent reoccurrence.</p> <p>During an interview on 12/6/2024 at 3:45 PM with Resident #1's family member (Health Care Proxy), they stated the facility called them and informed them on 11/13/2024, does not recall the time. The facility informed them that Resident #1 was observed in the room of a male resident and as a result, they would be changing Resident #1's room. The family member began crying and stated, This makes me want to vomit to recount this. The family member stated they went to the facility later that day and heard from a staff member on the unit that Resident #1 was witnessed to have male genitals in their mouth. Family member further stated that should not have occurred, and it saddened them deeply. The family member stated if Resident #1 had been cognitively intact they would have been very upset, humiliated, and embarrassed.</p> <p>415.4(b)(1)(i)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50951</p> <p>Based on observations, record review and interviews during the abbreviated Survey initiated on 8/4/2024 and completed on 8/09/2024 (NY00360500) the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for one (1) (Resident #1) of four (4) residents with the potential to affect 9 of 72 cognitively impaired residents reviewed for sexual abuse. Specifically, Resident #1 who had severely impaired cognition and was found in Resident #2's room by Licensed Practical Nurse #1 performing oral sex on Resident #2 (with intact cognition.). Additionally, the Administrator did not monitor and enhance the quality of care and services for Resident #1 after the abuse occurred or the potential for abuse for all (72) residents in the facility from 11/13/2020. This resulted in actual psychosocial harm to Resident #1.</p> <p>Refer to F600 Freedom from Abuse, Neglect, and Exploitation: Scope and Severity of J.</p> <p>The finding is:</p> <p>There was no documented evidence in the medical record that the facility evaluated Resident #1 for physical, mental, and psychosocial well-being or initiated interventions to protect Resident #1 and all other cognitively impaired residents in the facility.</p> <p>The Accident and Incident report dated 11/14/2024 documented Resident #1 as the alleged perpetrator, They (Resident #1) were having fun with a smile on their face. The incident was witnessed by a facility staff member (Licensed Practical Nurse #1). The incident report documented Resident #2 as the victim. Resident #2 stated it was consensual. The facility concluded no abuse, neglect or mistreatment occurred.</p> <p>Resident #1, [AGE] years old female, admitted with diagnoses including vascular dementia and depression with a Brief Interview for Mental status score of 7/15 indicating severely impaired cognition.</p> <p>Resident #2 [AGE] year-old male admitted with diagnoses including right leg above knee amputee, coronary artery bypass graft and hypertension, with a Brief Interview for Mental status score of 15/15 indicating complete intact cognition.</p> <p>During an interview with Licensed Practical Nurse #1 on 12/4/24 at 3:02 PM, they stated during a medication pass they went into Resident #2's room and witnessed Resident #2 sitting in their wheelchair by the window side of the bed wearing shorts and the shorts were pulled up along their right leg with the amputation. Resident #2 was holding their genitals and Resident #1 was in their wheelchair and was performing oral sex on Resident #2. Licensed Practical Nurse #1 stated they immediately separated the residents and notified the Nurse Supervisor.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview with the Administrator on 12/5/2024 at 4:37 PM, they stated they are aware of the incident involving Resident #1 and Resident #2. The Administrator further stated that they believe the sexual act between the residents were consenting because Resident #1 stated they were having fun and was smiling. The Administrator stated they notified Local Law Enforcement as a method of precaution.</p> <p>During an interview with the Psychiatrist on 12/6/24 at 7:11 PM they stated they saw Resident #1 about 2-3 times since their admission to the facility. They assessed Resident #1 a couple of days after the incident via Tele-Health, and the resident was unable to recall the incident. The Psychiatrist stated staff should be monitoring the resident for any negative effects. The Psychiatrist stated that the incident should never have occurred, and all efforts should be made to prevent reoccurrence.</p> <p>10 NYCRR 415.26</p>		