STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105441	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Health & Rehabilitation Center	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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, interview and record review, the facility failed to assess skin in a timely manner, to identify a pressure ulcer for 1 of 7 sampled residents reviewed for facility acquired pressure ulcers, Resident #408. The findings included: Review of the facility policy and procedure on 08/08/24 at 3:10 PM titled Pressure Injury Prevention and Management provided by the Director of Nursing (DON) revised 10/2022 documented in the Policy Statement: This facility is committed to the prevention of avoidable pressure injuries .and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries Policy Explanation and Compliance Guidelines: .2. The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. 3. Assessment of Pressure Injury Risk a. Licensed nurses will conduct a pressure injury assessment, using the Braden Scale, on all residents upon admission/re-admission, weekly x four (4) weeks, then quarterly or whenever the resident's condition changes significantly .c. Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Finding will be documented in the medical record. d. Assessments of pressure injuries will be performed by a licensed nurse, and documented in Point Click Care. The staging of pressure injuries will be clearly identified to ensure correct coding on the MDS. e. Nursing assistants will inspect skin during bath and will report any concerns to the resident's nurse immediately after the task .Monitoring a. The Unit Manager or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record. b. The attending physician will be notified of: i. The presence of a new pressure injury upon identification. ii. The progression towards healing, or lack of healing, or any pressure injuries weekly .6. Modifications of Interventions a. Any changes to the facility's pressure injury prevention and management processes will be communicated to relevant staff in a timely manner. b. Interventions on a resident's plan of care will be modified as needed. Considerations for needed modifications include: .ii New onset or recurrent pressure injury development . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure on 08/08/24 at 3:15 PM titled Notification of Changes provided by the DON revised 11/29/22 documented in the Policy Statement: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification .Compliance Guidelines: . Circumstances requiring notification include: .2. Significant change in the resident's physical, mental or psychosocial conditions such as deterioration in health, mental or psychosocial status iii. Exacerbation of a chronic condition. Resident #408 was admitted to the facility on [DATE] with diagnoses which included Unspecified Displaced Fracture of Seventh Cervical Vertebra, Paraplegia Incomplete, Spondylopathy, Muscle Wasting, Dysphagia, Neuromuscular Dysfunction of Bladder, Anemia, Depression, Adjustment Disorder, Quadriplegia Hypertension, Atherosclerotic Heart Disease, Gastroesophageal Reflux Disease, Ileus, Fusion of Spine and Edema. He had a Brief Interview Mental Status (BIM) score of 13 (cognitively intact). A telephone interview was conducted on 08/07/24 at 2:04 PM with Resident #408's family member, who is the Power of Attorney (POA). Resident #408's Niece stated that she was on her way, at the time, to visit her Uncle, who was currently in the Hospital again for the same wounds which are infected, in addition to being diagnosed with Pneumonia. Resident #408's Niece went on to say that the resident had to have another debridement for his level four (4) sacral wound; which she said that she had subsequently learned had actually been worse, than she was originally told to her by facility nursing staff members. She ended by saying that the resident has no history of any sacral wounds. On 05/30/24 the 3008 Agency for Healthcare Administration (AHCA) Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form did not document any pressure ulcers, lesions or wounds, at the time, for this resident. Record review revealed that on 05/30/24, Staff U, a Licensed Practical Nurse (LPN), documented in the following admission nursing progress note, Patient arrived at the facility on stretcher accompanied by two (2) attendants and family member. admitted to room B-26-B, alert and oriented able to make needs known to staff. Skin warm to touch, scar to the neck, open area to right shin, dried blister to left heel, swelling to bilateral feet. Patient has neck brace. Patient not able to move arms and legs, very immobile, fingers are stiff. Denies any pain. No acute distress noted. Vital signs 134/60, O2 sat 100%, T97.7 P74. Will continue to monitor; with no mention of the status of Resident #408's sacral skin region. Record review of Resident #408's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 05/30/24 indicated that the resident had a score of 13 which indicated that he was at Moderate risk. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 08/08/24 at 9:47 AM with Staff X, a Certified Nursing Assistant, (CNA), in which she stated that Resident #408 was totally dependent for care. She said that she fed him, washed and cleaned his entire body and dressed him, with staff member assistance. She stated that she worked with this resident on day shift for five (5) days from Tuesday 06/04/24 until Saturday 06/08/24. Staff X said that Resident #408 did not come into the facility with any open areas on his sacral/bottom area during this time, and she added that if she had seen any redness, open areas, abrasions, rash or anything of this kind, she would have reported it to the nurse. Staff X went on to say that she repositioned this resident every 2 hours on her shift, she said that she cleaned and checked the resident's sacral area on a daily basis and entered the information in the mounted computerized CNA tablet, located in the hallway of the B-wing, which documented how the resident ate, if he was continent or incontinent, if he had a bowel movement or not, the presence of a Foley catheter and the skin condition. Staff X stated and documented, that on Tuesday June 4th at 1:16 PM, she showered, Resident #408, while still in bed and on Thursday June 6th at 1:28 PM, Resident #408 had a small bowel movement, and she cleaned and changed him. Finally, Staff X stated that from Wednesday 06/05/24 until Tuesday 06/11/24 for two (2) hours daily, that both she and Staff Y, the facility Physical Therapist, who also corroborated this to the Surveyor on 08/08/24 at 11:25 AM, would get Resident #408 out of bed utilizing the Hoyer lift into a recliner wheelchair. According to record review of the CNA Task list form, Staff Z, documented, that she showered, Resident #408, while still in bed and on Friday June 7th at 10 PM it was also documented that the resident had a medium bowel movement, and she cleaned and changed him on that day. Staff W, a Licensed Practical Nurse (LPN) Wound Care Nurse, who recorded the Tuesday 06/11/24 Sacral Wound Physician treatment order, and who was primarily responsible for Resident #408's sacral wound care during his short, facility stay, was out of the facility and unavailable for telephone interview, during the survey. A subsequent side-by-side record review was conducted of the Wound Care Doctor's progress notes, completed by the Advanced Registered Nurse Practitioner (A.R.N.P.) along with the facility's current Wound Care Director on 08/08/24 at 11:24 AM in which it was noted that, The initial sacral Stage III wound measurements were: 10.0 x 10.0 x 0.1 cm and the surface area was 100.00 sq.cm. on 06/11/24; no tunneling or undermining, moderate amount of serosanguinous drainage with no odor, pain level 01/10, 60% granulation, 10% epithelization; no eschar present. The Physician's order for wound care were: Normal saline, skin prep, Hydrogel, bordered dressing daily and PRN. The sacral wound measurements vs. wound presentation were: 10.0 x 10.0 x 0.1 cm and the surface area was 100.00 cm. on: 06/18/24; no tunneling or undermining, moderate amount of serous drainage with no odor, pain level 01/10, 20% granulation, 0% epithelization; no eschar present with no change in wound progression. The Physician's order for wound care were: Normal saline, skin prep, Hydrogel, bordered dressing daily and PRN. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound evaluation done by ReNew 6/25/24 shows sacral wound remains 'Un-stageable and measures 10 x 8 x 0.4, no significant change since last week, moderate serous exudate, 80% Slough, 20% Granular, mild odor, denies pain. The sacral wound measurements vs. wound presentation (Post-debridement) were: 10.0 x 8.0 x 3.8 cm and the surface area was 80.00 cm. on: 06/25/24; no tunneling or undermining, moderate amount of serous drainage with no odor, pain level 01/10, 20% granulation, 0% epithelization; no eschar present with no change in wound progression. The Physician's order for wound care: treatment changed to 1/4 strength Dakin's moistened gauze packing and cover with bordered dressing daily and PRN; family and attending physician made aware. For the month of May and June 2024, the Medication Administration Record (MAR) documented a physician's order for a blood thinner medication for Resident #408: Enoxaparin Sodium Solution 40 mg/0.4ml Inject 40 mg subcutaneously (SQ) every twelve (12) hours for blood clotting prevention for ten (10) Days that were initialed by licensed nursing staff as being provided to this resident, and for Aspirin Enteric Coated (EC) Tablet Delayed Release 325 MG (Aspirin) Give one (1) tablet by mouth one (1) time a day for Coronary Artery Disease (CAD) with breakfast. For the month of May and June 2024, the Treatment Administration Record (TAR) documented two (2) physician's orders, beginning prior to Tuesday 06/11/24 for the following: 1) Cleanse right and left buttocks with soap and water. Apply Lantiseptic cream after each brief change every shift for prophylaxis - start date Thursday 06/06/24, and 2) Turn and re position frequently as tolerated every shift for preventative measure - start date Wednesday 06/05/24. During an interview conducted on 08/08/24 at 10:22 AM with Staff AA, RN, she stated that she was part of the nursing staff who cared, for this resident, at bedside, prior to Tuesday June 11th on the following seven (7) days: Friday 05/31/24, Tuesday June 4th, Wednesday June 5th, Friday June 7th , Saturday June 8th, Sunday June 9th and Monday June 10th , for the entire week on day shift. Staff AA stated that on: Friday 05/31/24, she noticed immediately upon entering Resident #408's room, that he was, sweaty, smelling badly with his beard looking overgrown and unkempt. As a result, Staff AA stated that she asked Resident #408 if he was ok, with her giving him a shave, a good, full entire bath and nail trimming; which he agreed. Staff AA stated that on that same day, she and another aide proceeded to provide this care for him, but Staff AA also said that she saw no open skin areas on his sacrum. Staff AA added that she had not gone back at any other time during that week to see Resident #408's sacral area. Staff AA also became emotional and tearful, during the interview, indicating that when she had learned later about the resident's wound being found on his sacral, she added that, when she saw the Resident #408's skin it was just shiny and black to her, and she added that she, felt so bad about it once she was aware of and realized what had happened. On 08/08/24 at 12:25 PM an interview was conducted with, the Advanced Registered Nurse Practitioner (A.R. N.P.) for Wound Care working with Renew Wound Care Consultants, regarding the on-set of Resident #408's facility-acquired sacral wound. The A.R.N.P. stated that she had not seen Resident #408 prior to Tuesday June 11th. She said that she did not see or assess the resident until Tuesday June 11th and she saw him again one (1) week later on Tuesday June 18th and again on Tuesday June 25th. She acknowledged that all necessary preventative skin measures/interventions, should have been put into place, for this resident, to maintain skin integrity, beginning upon admission to the facility. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/08/24 at 1:06 PM a telephone interview was conducted with, Resident #408's Primary Care Physician (PCP)'s regarding the on-set of the resident's facility-acquired sacral wound. Resident #408's PCP stated and documented that either he or his A.R.N.P., had been in the facility to see this resident on Friday 05/31/24, Tuesday 06/04/24 and again Friday Tuesday 06/07/24. The Doctor stated that he believed that Resident #408 developed a Deep Tissue Injury (DTI) to that area, and he had very dark skin hyperpigmentation making it almost impossible to detect changes in his skin in addition to his other co-morbidities and he stated that, it would have happened anyway. Resident #408's PCP said that he personally saw and assessed Resident #408's sacral skin area with his A.R.N.P. He added that he was not aware of Resident #408's current status or condition. Resident #408's PCP also acknowledged that all necessary preventative skin measures/interventions, should have been put into place, for this resident, to maintain skin integrity, beginning upon admission to the facility. Record review of Resident # 408's CNA ADL (Activities of Daily Living) Task Flowsheet Record dated Thursday 05/30/24 thru Tuesday 06/11/24 revealed that for at least three (3) of the facility's CNA staff working with this resident on both the day and evening shifts documented that they had actually provided the following (ADL)'s of: Bathing support, Shower in bed, and Bowel elimination for the resident. Record review of Resident #408's Baseline care plan dated Friday 05/31/24 indicated that the resident was alert and cognitively intact and required extensive assistance for bed mobility, dressing, hygiene and bathing. He was also totally dependent for transfers, locomotion and toileting. Resident #408's only skin tegrity issues, at that time, were Cellulitis and Edema to leg. Resident #408's subsequent Care plans initiated on 05/31/24 for ADL self-care performance deficit and on 06/02/24 for potential and actual impairment to skin integrity was relative to the resident's disease process, impaired balance/mobility and fragile skin. The following interventions were listed: resident is totally dependent on two (2) staff to provide bath/shower resident is totally dependent on one (1) staff for personal hygiene and oral care follow facility protocols for treatment of injury, keep skin clean and dry, weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. The goals noted for Resident #408 were to improve current level of functioning through the review date and to maintain or develop clean and intact skin by the review date. A side-by-side record review was also conducted with the DON of the facility's progress notes, at that time, of the resident's skin status. However, the documentation reviewed in the progress notes, weekly Skin Only Evaluation and in the daily Skilled Evaluations forms dated Friday 05/31/24 up until Tuesday 06/11/24) only documented the general condition or status of the resident's skin area as: warm and dry, skin color within normal limits (wnl) and Turgor is normal, no edema or pitting edema present to lower extremities, and turgor normal, warm to touch, circulation check; extremities are warm and pink, Capillary Refill: Brisk < 3 seconds, skin negative for rash or bruising, no skin lesions or rashes appreciated in exposed bilateral upper extremities or bilateral lower extremities., patient has high risk for developing .ulcers and for skin breakdown which can progress to sepsis ., but with no documentation to specifically describe the resident's sacral area, as having been assessed by facility staff. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In Summary, Resident #408 had been residing in the facility, seen and cared for by several different nursing staff members, for eleven (11) days, before the resident's sacral wound was discovered at a stage III; with subsequent treatment then being initiated by facility nursing staff, with no timely notification made to the resident's representative of such. The DON recognized and acknowledged during interview on 08/08/24 at 3:47 PM, that Resident #408's sacral skin wound was not discovered, identified nor documented on by the facility's nursing staff until Tuesday 06/11/24; eleven (11) days after admission to the facility.