STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was electronically sent to the facility on 01/13/22.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents with six reviewed for activities of daily living (ADLs). Based on observation, record review, and interview the facility failed to provide Resident (R) 7 with the appropriate fitted shoes, placing him at risk for falling. Findings included: - The "Electronic Medical Record" (EMR), documented R7 had diagnoses of generalized muscle weakness, abnormalities of gait and mobility, and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain). R7's "Annual Minimum Data Set" (MDS), dated 10/16/21, documented the resident had short and long term memory problems, independent with ADLs except supervision with eating. R7's MDS documented it was very important to him to choose what clothes to wear.	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/13/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 1	F 558		

R7's "ADL Care Area Assessment" (CAA) documented R7 used a cane when ambulating.

R7's "ADL Care Plan," revised on 10/20/21, documented the resident independent with dressing but may require staff supervision to ensure the task is being completed.

Review of R7's "Progress Notes," from 10/25/21-01/05/22, revealed lack of documentation regarding his shoes being too big.

On 01/05/22 at 07:35 AM, observation revealed R7 ambulated with a cane down the hall wearing slippers that had approximately one inch gap behind his heel, shuffling as he ambulated.

On 01/06/22 at 08:10 AM, observation revealed R7 ambulated down the hall, using a cane, with the same house slippers on, shuffling as he ambulated.

On 01/10/22 at 08:44 AM, observation revealed R7 sat at the dining room table in a chair and his slippers had approximately one inch gap behind his heel.

On 01/06/22 at 09:30 AM, Certified Nurse Aide (CNA) N stated R7 had the slippers since she became employed a year ago, she stated she did not know if he had any other shoes, because R7 was a very private person and does not let staff in his room very often, only if he has a room tray or needed water.

On 01/10/22 at 10:32 AM, Licensed Nurse (LN) H stated the slippers were too big but were probably better than the shoes he had previously.

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F 558	Continued From page 2	F 558		

On 01/06/22 at 09:22 AM, Social Service Staff X stated R7 had stopped in his office today and talked to him about slippers being too big.

On 01/10/22 at 10:08 AM, Social Service Staff X stated R7 did let him into his room to search for another pair of shoes, and there were none, so he contacted R7's family and instructed them to bring R7 another pair that fit.

On 01/10/22 at 11:50 AM, Social Services X stated the procedure if R7 needed something was he would purchase the item and then charge the resident. Social Service Staff X stated he would get the resident a new pair of slippers or shoes today and R7 had those slippers since April of 2021.

On 01/10/22 at 11:55 AM, Administrative Nurse D stated she was unaware the resident's slippers were too big for him and she would check into it. Administrative Nurse D stated Social Services X should have money to obtain the proper fitting shoes for the resident.

The facility's undated "Social Service Designee Job Description" policy documented the SSD would provide for medically related social services to attain or maintain the highest practicable physical, mental or psychosocial well being of each elder resident residing in the facility home. These services would be offered to assist the elder and elders' family members in maintenance and improvement of each elder's ability to control everyday physical needs, mental needs, and psychosocial needs.

The facility failed to provide R7 with appropriately

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 3 fitted shoes, placing the resident at risk for falls.	F 558		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 582	Continued From page 4	F 582		

transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents with four reviewed for Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on record review and interview, the facility failed to provide form CMS 10055, "Advanced Beneficiary Notice" (ABN), which included the estimated cost for continued services for skilled services to the resident or their representative for the four residents, Resident (R) 24, R82, R83, and R84. This deficient practice placed all four residents at risk for uninformed decisions and unanticipated costs related to skilled services.

Findings included:

- The Medicare ABN form informed the beneficiaries that Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included an option for the beneficiary to (1) receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 582	Continued From page 5	F 582		

specified services listed, and bill Medicare for an official decision on payment. I understand if Medicare does not pay, I will be responsible for payment, but can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment of services. Or (3) I do not want the listed services.

The facility lacked documentation staff provided R24 or their representative the ABN form 10055 when the resident's skilled services ended 11/25/21. The facility provided a facility-generated form which lacked a cost estimate for continued services.

The facility lacked documentation staff provided R82 or their representative the ABN form 10055 when the resident's skilled services ended 09/30/21. The facility provided a facility-generated form which lacked a cost estimate for continued services.

The facility lacked documentation staff provided R83 or their representative the ABN form 10055 when the resident's skilled services ended 09/13/21. The facility provided a facility-generated form which lacked a cost estimate for continued services.

The facility lacked documentation staff provided R84 or their representative the ABN form 10055 when the resident's skilled services ended 07/11/21. The facility provided a facility-generated form which lacked a cost estimate for continued services.

On 01/06/22 at 08:30 AM, Social Service Staff X verified the facility had not provided the cost estimate for continued services and had not used

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	175422	A. BUILDING _____ B. WING _____	01/10/2022

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F 582	Continued From page 6 the specific CMS form 10055. Social Service Staff X stated he was not aware of the estimated cost for the above residents to continue services if they requested. Upon request the facility failed to provide a policy regarding beneficiaries. The facility failed to provide R24, R82, R83 and R84 with the appropriate non-coverage notice and cost estimate for further services, placing the residents at risk for uninformed decisions regarding skilled services.	F 582		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 7	F 625		

the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents with one reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to provide the resident or resident representative with written information regarding the facility bed hold policy, when Resident (R) 8 was transferred to the hospital. This placed R8 at risk for not being permitted to return and resume residence in the nursing facility.

Findings included:

- R8's "Electronic Medical Record" (EMS) documented the resident had diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance, hallucinations (sensing things while awake that appear to be real, but the mind created), and age related cognitive decline.

R8's "Quarterly Minimum Data Set" (MDS), dated 10/20/21, documented the resident had a Brief Interview of Mental Status (BIMS) score of two, which indicated severe cognitive impairment. R8's MDS documented the resident required extensive staff assistance with toilet use, limited staff assistance with the rest of activities of daily living (ADLs) except independent with eating.

R8's "Elopement Risk/ Wanderer Related to

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F 625	Continued From page 8	F 625		

Dementia Care Plan," dated 10 /20/21, documented R8 would be physically aggressive towards staff and others and instructed staff to analyze times of day, places, circumstances, triggers and what de-escalated behavior and document the behavior. R8's care plan instructed staff to assess and address for contributing sensory deficits, resident's needs, and order to have psychiatric evaluation and inpatient treatment if needed. R8's care plan instructed staff to redirect him when he became agitated or aggressive and place the resident on 1:1 care until an order received from physician releasing 1:1 care.

R8's "Behavior Note," dated 12/20/21 at 11:27 PM, documented at the start of the shift, R8 started yelling at another resident and approached the resident. A charge nurse stepped between the residents to redirect them and R8 hit the charge nurse in the back. R8 was assisted away from others.

R8's "Progress Note," dated 12/27/21 at 10:26 AM, documented staff received an order from the physician for referral to a psychiatric unit.

R8's "Progress Note," dated 12/28/21 at 06:45 AM, documented R8 left the facility accompanied by staff to be admitted to the behavioral health facility.

Review of R8's "Progress Notes" revealed lack of documentation the resident or representative was provided a bed hold policy.

On 01/05/22 at 04:30 PM, observation revealed R8 returned to the facility with staff, who assisted him to the elevator and to the nursing home.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

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F 625	Continued From page 9	F 625		

Continued observation revealed R8 alert, quiet, and cooperative with staff.

On 01/06/22 at 01:01 PM, Licensed Nurse (LN) H stated she sent paperwork with R8 when he left to go to the behavioral health facility. LN H stated the paperwork sent included R8's "Medication Administration Record" (MAR), physician orders, and transfer papers, but did not include the bed hold policy.

On 01/06/22 at 01:19 PM, LN I stated the facility goes over the bed hold policy on admission to the facility and verified she had not sent one with the resident or representative on transfer to the behavioral hospital. LN I also verified she did not review the bed hold policy with the resident or his representative.

The facility's undated "Bed Hold" policy documented before the facility transfers a resident to a hospital or the resident goes on therapeutic leave, the facility would provide written information to the resident and/or resident representative that specifies: the duration of the state bed hold policy during which the resident is permitted to return and resume residency in the facility; the reserve bed payment policy in the state plan; the facility's policies regarding bed hold period, which are consistent with the law permitting the resident to return .

The facility failed to provide R8 or his representative with the bed hold policy when he was transferred to the behavioral hospital, placing the resident at risk for not being permitted to return and resume residence in the nursing facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

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F 692	Continued From page 10	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents with one reviewed for nutrition. Based on observation, record review, and interviews the facility failed to implement the Registered Dietician's (RD) recommendations for Resident (R) 13, who had a documented weight loss. On 11/19/21 the RD recommended to increase R13's Med Pass 2.0 (a high calorie nutritional supplement) from 60 milliliters (ml) three times daily to 120 ml three daily in response to a 4.11 percent (%) unintended weight loss in 43 days. The facility failed to implement the recommendation until 01/06/22 at which time R13	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 692	Continued From page 11	F 692		

had a significant weight loss of 11.47 % in three months.

Findings included:

- R13's "Electronic Medical Record" (EMR) listed diagnoses of mild cognitive impairment, weakness, frontotemporal dementia (group of brain disorders that primarily affect the frontal and temporal lobes of the brain which are generally associated with personality, behavior and language), and functional dyspepsia (indigestion).

R13's "Significant Change Minimal Data Set," (MDS), dated 02/18/21 documented the resident had a Brief Interview of Mental Status (BIMS) of one. The MDS documented R13 required extensive assistance with activities of daily living (ADLs) except supervision with eating. The MDS documented R13 had no swallowing disorder or no dental problems. The MDS recorded R13 weighed 105 pounds.

R13's "Nutritional Care Area Assessment" (CAA) triggered due to R13's low body mass index (BMI) (measure of body fat based on height and weight that applies to adult men and women), her current weight on 02/12/21 was 107.4 pounds; weight approximately one month ago on 01/04/21 was 115.2 lbs and weight approximately six months prior on 08/10/20 was 119.2 lbs. The CAA documented R13 ate a regular diet with regular food and fluid consistency and did receive med pass three times a day for increased calorie intake. The CAA documented the residents meal intake fluctuated.

R13's "Quarterly MDS," dated 11/19/21, documented R13 had short and long-term

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F 692	Continued From page 12	F 692		

memory problems and severely impaired cognition. The MDS documented R13 required extensive staff assistance with ADLs and had upper and lower extremity impairment on both sides. The MDS recorded R13 weighed 115 pounds and had no weight loss.

R13's "ADL Care Plan," revised on 11/24/21 documented R13 required extensive staff assistance with eating.

R13's "Nutrition Care Plan," revised on 11/24/21, documented R13 had a potential for nutritional problem and swallowing issues pertaining to a diagnosis of dyspepsia. She had a gradual weight loss pertaining to dementia. The care plan instructed staff to monitor and record R13's intake every meal. The care plan further directed the RD to evaluate and make diet change recommendations as needed.

The "Care Plan" lacked direction regarding specific interventions implemented to prevent or reduce unintended weight loss.

R13's EMR recorded the following weights:
09/30/21-116.8 pounds (lb)
10/28/21-112.4 lbs.
11/04/21-111.2 lbs.
11/12/21-112 lb. (4.11 % loss in 43 days)
11/26/21-112.2 lbs.
12/07/21-107.8 lbs.
12/24/21-104.8 lbs.
12/31/21-103.4 lbs. (11.47 % loss in 92 days)

The "Nutrition/Dietary Note" dated 09/27/21 documented R13's weight was 114.8 lbs. R13's weight fluctuated between 107-120.6 lbs. during the past six months. R13 received a regular diet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 692	Continued From page 13	F 692		

and her intake was variable with an average 50% consumption per documentation. She received Med Pass 2.0 60 ml three times a day. The note recorded staff continued with R13's current dietary plan and monitored her weight trends. The goal was weight maintenance with no significant weight changes.

The "Nutrition/Dietary Note" dated 11/19/21 documented R13's weight was 112 lbs. which was down 2 lbs. in one week. R13 received a regular diet and her intake was variable with an average 50% consumption per documentation. She received Med Pass 2.0 60 ml three times a day. The note documented a recommendation to increase the Med Pass 2.0 to 120 ml three times daily and monitor weight trends.

A "Physician Order" dated 01/28/21, instructed staff to administer to R13 Med Pass 2.0 (60 ml) three times a day (TID) to increase caloric intake.

R13's November 2021 "Medication Administration Record (MAR)" documented staff administered Med Pass 2.0 60 ml three times a day with no refusals.

R13's December 2021 MAR documented staff administered Med Pass 2.0 60 ml three times a day with no refusals.

On 01/05/22 at 08:15 AM, observation revealed R13 sat in a wheelchair at the dining room table and Licensed Nurse (LN) G administered 60 ml of Med Pass 2.0 to the resident. R13 consumed 100% of the supplement.

On 01/05/22 at 12:45 PM, observation revealed R13 sat in a wheelchair at the dining room table.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 692	Continued From page 14	F 692		

Staff served her mashed potatoes with gravy, ground chicken strip, cooked broccoli, 180 ml of juice, and 180 ml of water. Observation revealed staff assisted R13 to eat. At 01:15 PM, R13 consumed a few bites of her food and drank 50% of her fluids. Staff did not offer her any other food items.

On 01/10/22 at 09:54 AM, Certified Nurse Aide (CNA) M stated R13 had days she would not eat and some days she would eat well. CNA M stated the CNAs checked R13's weight and if she had a weight loss, staff notified the Director of Nursing (DON).

On 01/10/22 at 10:15 AM, Licensed Nurse (LN) H stated the CNAs weighed the resident and let nursing know if she had a weight loss. LN H said if the RD made a recommendation, dietary staff would give nursing a sheet of paper with the recommendation and nursing staff faxed the physician for an order for the recommendation.

On 01/06/22 at 02:30 PM, Administrative Nurse D verified the RD recommendation on 11/19/21 had not been implemented. Administrative Nurse D stated the recommendation had not been communicated to the nursing department, so the order was not entered into R13's EMR. Administrative Nurse D stated the Dietary Manager received the recommendation, but had not relayed it to the nursing department.

On 01/10/22 at 01:17 PM, Administrative Staff A stated she had not received a report on 11/19/21 from the RD with recommendation to increase R13's Med Pass 2.0 from 60 ml to 120 ml three times a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

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F 692	Continued From page 15 On 01/10/22 at 12:42 PM, Certified Dietary Manager (CDM) BB stated when the RD made the recommendations to increase R13's Med Pass on 11/19/21, she sent an e-mail to her and the DON. On 01/10/22 at 12:51 PM, RD GG stated she typically sent a report by e-mail to the CDM, administrator, and DON. RD GG said she did not have the DON's e-mail, so did not send the report from 11/19/21 to the DON. RD GG said CDM BB should pass the report on to nursing staff. RD GG expected nursing to implement the recommendation or if nursing staff observed the recommendation was not implemented, to follow up with the RD or a physician. In an email communication received on 01/11/22, Administrative Staff A provided a "Physician's Order" dated 01/10/22 which documented R13's weight loss was unavoidable due to her dementia. The undated " Standing Orders" policy documented nutrition supplements may be started as a dietician measure for weight loss. The facility failed to implement the RD's 11/19/21 recommendation to increase R13's Med Pass 2.0 from 60 ml to 120 ml three times a day. R13 had an unintended significant weight loss of 11.47 % in three months.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 16	F 756		

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

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F 756	Continued From page 17	F 756		

facility's Consultant Pharmacist failed to report to the Director of Nursing, physician, and medical director the failure to identify an inappropriate diagnosis and monitor behaviors for the use of an antipsychotic medication (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions) for one of five sampled residents, Resident (R) 22. This placed R22 at risk for adverse side effects.

Findings included:

- R22's "Physician Order Sheet," dated 12/01/21, recorded the diagnoses of dementia with behavioral disturbance (agitation, wandering, verbal and physical aggression).

The "Quarterly Minimum Data Set" (MDS), dated 12/10/21, recorded R22 had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS recorded the resident required moderate assistance with bed mobility and transfers. The MDS further recorded R22 received antipsychotic medication on a daily basis.

The "Care Plan," dated 12/01/21, for antipsychotic use directed staff to monitor R22 for behaviors. The care plan recorded the resident received Risperdal (an antipsychotic medication) with the following Black Box warning (BBW - strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug). Risperdal is not approved for dementia due to the medication is not effective for the treatment of dementia, and can increase

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 756	Continued From page 18	F 756		

mortality (death) risk and adverse side effects in the elderly.

The "Physician Order," dated 04/08/21, directed the staff to administer Risperdal 0.5 milligrams (mg) by mouth (PO) every AM and Risperdal 1 mg PO at 06:00 PM daily.

The facility's "Behavior Monitoring Documentation" for April, May, June, July, August, September, October, November, December 2021 and January 1-10, 22 revealed no documented behaviors for the use of the Risperdal.

Review of the Registered Pharmacist monthly medication reviews for: 04/10/21, 05/12/21, 06/15/21, 07/10/21, 08/05/21, 09/10/21, 10/01/21, 11/12/21, and 12/02/21 revealed no documentation of an inappropriate diagnosis for the use of the Risperdal, or the lack of behavior monitoring.

The medical record lacked documentation of any Abnormal Involuntary Movement Scale (AIMS -an assessment that is used to track any abnormal body movements due to the use of an antipsychotic medication, which can indicate tardive dyskinesia) (abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk).

On 01/05/22 at 08:10 AM, observation revealed R22 seated in her wheelchair in the dining room at a table eating breakfast.

On 01/05/22 at 09:30 AM, Licensed Nurse (LN) H stated if a resident received an antipsychotic

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	175422	A. BUILDING _____ B. WING _____	01/10/2022

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SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 756	Continued From page 19 medication, documentation of behaviors were to be completed every shift on the treatment sheet. On 01/06/22 at 10:00 AM, Administrative Nurse D verified the resident diagnosis of dementia with behavioral disturbance for the use of the Risperdal was not an appropriate diagnosis and no behavior monitoring or AIMS assessment had been documented. The facility's undated "Antipsychotic Drugs" policy stated the elder's need for the psychotropic medication will be monitored, as well as when the elder has received optional benefits from the medication and when the medication dose can be lowered or discontinued. The physician's order for a psychotropic medication will include both a qualifying diagnosis for the drug and a list of target behaviors which the staff will monitor during the drug administration. The nurse will be responsible for initiating a Behavior Monitoring process based on the qualifying diagnosis and the specific target behaviors for each drug. The facility's Consultant Pharmacist failed to report to the Director of Nursing, physician, and medical director the failure to identify an appropriate diagnosis for the use of the antipsychotic medication, or assess for behaviors for the use of Risperdal for R22, placing the resident at risk for adverse side effects.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

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F 758	Continued From page 20	F 758		

but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 21	F 758		

drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to identify an inappropriate diagnosis and monitor behaviors for the use of an antipsychotic medication (class of medications used to treat any major mental disorder characterized by a gross impairment in reality testing and other mental emotional conditions) for one of five sampled residents, Resident (R) 22. This placed R22 at risk for adverse side effects.

Findings included:

- R22's "Physician Order Sheet," dated 12/01/21, recorded the diagnoses of dementia with behavioral disturbance, (agitation, wandering, verbal and physical aggression).

The "Quarterly Minimum Data Set" (MDS) , dated 12/10/21, recorded R22 had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS recorded the resident required moderate assistance with bed mobility and transfers. The MDS further recorded R22 received antipsychotic medication on a daily basis.

The "Care Plan," dated 12/01/21, for antipsychotic use directed staff to monitor R22 for behaviors. The care plan recorded the resident received Risperdal (an antipsychotic medication)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

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F 758	Continued From page 22	F 758		

with the following Black Box warning (BBW - strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug). Risperdal is not approved for dementia due to the medication is not effective for the treatment of dementia, and can increase mortality (death) risk and adverse side effects in the elderly.

The "Physician Order," dated 04/08/21, directed the staff to administer Risperdal 0.5 milligrams (mg) by mouth (PO) every AM and Risperdal 1 mg PO at 06:00 PM daily.

The facility's "Behavior Monitoring Documentation" for April, May, June, July, August, September, October, November, December 2021 and January 1-10, 22 revealed no documented behaviors for the use of the Risperdal.

The medical record lacked documentation of any Abnormal Involuntary Movement Scale (AIMS)(an assessment that is used to track any abnormal body movements due to the use of an antipsychotic medication, which can indicate tardive dyskinesia)(abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk).

On 01/05/22 at 08:10 AM, observation revealed R22 seated in her wheelchair in the dining room at a table eating breakfast.

On 01/05/22 at 09:30 AM, Licensed Nurse (LN) H stated if a resident received an antipsychotic

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	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 758	Continued From page 23 medication, documentation of behaviors were to be completed every shift on the treatment sheet. On 01/06/22 at 10:00 AM, Administrative Nurse D verified the resident diagnosis of dementia with behavioral disturbance for the use of the Risperdal, was not an appropriate diagnosis and no behavior monitoring or AIMS assessment had been documented. The facility's undated "Antipsychotic Drugs" policy stated the elder's need for the psychotropic medication will be monitored, as well as when the elder has received optional benefits from the medication and when the medication dose can be lowered or discontinued. The physician's order for a psychotropic medication will include both a qualifying diagnosis for the drug and a list of target behaviors which the staff will monitor during the drug administration. The nurse will be responsible for initiating a Behavior Monitoring process based on the qualifying diagnosis and the specific target behaviors for each drug. The facility failed to have an appropriate diagnosis for the use of the antipsychotic medication, or assess for behaviors for the use of Risperdal for R22, placing the resident at risk for adverse side effects.	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 24	F 804		

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. Based on observation, record review, and interview the facility failed to prepare four residents' pureed diets by methods that conserve nutritive value when staff failed to measure ingredients and serving sizes for each residents' plate, placing the residents at risk for nonnutritive food items and inappropriate serving size of each food item.

Findings included:

- On 01/06/22 at 11:03 AM Dietary Staff (DS) CC stated the facility had four pureed diets of meat. Further observation revealed DS CC placed three 4 ounce (oz) servings of broccoli into a blender container, poured an unmeasured amount of hot water from the dispenser into the blender and blended the ingredients together, to make the consistency of pudding. Observation revealed DS CC poured the unmeasured ingredients onto three divided plates. DS CC placed four (4 oz) chicken fried steaks into a clean blender container, added unmeasured beef broth into the container and blended to consistency of pudding. Further observation revealed DS CC poured the unmeasured pureed chicken fried steak into three small custard bowls.

The "Pureed Broccoli Recipe" instructed staff for five servings to use 1-1/4 lbs broccoli frozen cuts, 3 tablespoons (tbs) instant thickener and 1 tbs butter. Remove drained portions from prepared recipe, place in food processor, process until fine in consistency, add thickener and melted

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	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 804	Continued From page 25	F 804		

margarine. May need to add some of the cooking liquid to reach desired consistency. Process until smooth, scrape down sides of processor with rubber spatula and process for 30 seconds. Reheat to serving temperature. Provide 1/2 cup servings for each resident.

The "Pureed Chicken Fried Steak Recipe" instructed staff for five servings to place 15 oz chicken fried steaks, one cup and three tbs of beef broth. The recipe instructed staff to remove portions from prepared recipe and process until fine in consistency, combine hot broth and thickener, and add the hot broth and thickener gradually to meat while processing. The recipe documented all of the liquid may not be required. The recipe instructed staff to scrape down sides of processor with a rubber spatula and process 30 seconds. Reheat to serving temperature, and provide a three oz scoop for each resident.

On 01/06/22 at 11:15 AM, DS CC verified she had not measured the ingredients in the above observation.

On 01/06/22 at 11:30 AM, Certified Dietary Manager (CDM) BB stated dietary staff should measure all ingredients when preparing the pureed diets.

Upon request the facility failed to provide a policy regarding pureed recipes.

The facility failed to measure ingredients when preparing the pureed recipes and when placing the pureed food items on the four pureed diet plates, placing the residents at risk for receiving nonnutritive value food items and inappropriate serving size of food items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included 12 residents. Based on observation and interview, the facility staff failed to store, distribute, and serve food in accordance with professional standards in 1 of 1 facility kitchens when staff touched a trash can lid, touched other objects, and continued to serve residents with the same contaminated gloves, when staff placed three different types of meat in the same container to thaw, and failed to label ice cream with an expiration date. This placed the 29 residents who resided in the facility and received meals from the facility kitchen at risk for acquiring a food borne illness. Findings included:	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	01/10/2022

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F 812	Continued From page 27	F 812		

- 01/04/22 at 08:58 AM, observation revealed in the walk-in refrigerator, in the kitchen, a package of ham slices, a 12 ounce (oz) package of bologna, and a 32 oz package of sliced turkey breast thawing in the same pan.

On 01/04/22 at 08:58 AM, observation revealed in the snack refrigerator four strawberry, two chocolate, two vanilla, and two orange containers of ice cream without an expiration date.

On 01/05/22 at 11:20 AM, observation revealed during the noon meal service, DS CC applied gloves, touched the steam table, then the trash can lid, then with the same contaminated gloves held a chicken fried steak on a resident's plate while cutting it up.

On 01/04/22 at 08:58 AM, CDM BB verified the bologna, ham slices, and sliced turkey breast were thawing in the same pan and stated she was unaware they should not be together. CDM BB stated she had always placed different types of meat together when thawing.

On 01/05/22 at 11:20 AM, DS CC verified she had touched the steam table and the trash can lid, then held a resident's chicken fried steak with the same contaminated gloves and stated she should have changed gloves.

On 01/05/22 at 12:46 PM, CDM BB stated staff should not touch resident food items with contaminated gloves.

On 01/05/22 at 01:00 PM, CDM BB verified the ice creams in the snack refrigerator were not dated with expiration dates and dated them.

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F 812	Continued From page 28 Upon request the facility failed to provide a policy regarding changing of gloves and food storage. The facility failed to store, distribute, and serve food in accordance with professional standards for food service safety for the 29 residents who resided in the facility and received food from the facility kitchen, placing the residents at risk for acquiring a food borne illness.	F 812		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of	F 849		

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F 849	Continued From page 29	F 849		

the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing;

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F 849	Continued From page 30	F 849		

counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to

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F 849	Continued From page 31	F 849		

assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the

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F 849	Continued From page 32	F 849		

facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 29 residents. The sample included 12 residents with one reviewed for hospice services. Based on observation, record review and interview, the facility failed to establish and document routine communication between the hospice provider and facility staff which included a plan of care available to facility staff directing what services, equipment, and medication were provided to Resident (R) 21, placing him at risk for delayed or inadequate cares due to lack of communication and/or collaberation between facility staff and hospice care providers.

Findings included:

- R21's "Electronic Medical Record" (EMR) documented the resident had diagnoses of acute kidney failure (condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few days), occlusion and stenosis of carotid artery (narrowing of the blood vessels (carotid arteries) in the neck restricting the blood flow to brain and head), and bradycardia (slow heart rate).

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F 849	Continued From page 33	F 849		

The "Quarterly Minimum Data Set" (MDS), dated 12/10/21, documented R21 had short and long-term memory problems and severely impaired cognition. R21's MDS documented the resident required extensive staff assistance with bed mobility, transfers, dressing, and toilet use, limited staff assistance with ambulation in room, locomotion on and off unit, and personal hygiene, and independent with eating. R21's MDS lacked documentation the resident received hospice services.

R21's "Care Plan," revised on 12/08/21, lacked a section regarding hospice services instructing staff when hospice staff were coming to facility and what cares they would provide.

Review of R21's "Hospice Folder" revealed documentation when hospice staff came to the facility but lacked a hospice care plan which included a detailed description of the services and supplies necessary to provide palliative (therapy designed to relieve or reduce intensity of uncomfortable symptoms) care for R21.

R21's "Meadowlark Hospice and Sunset Home Agreement," dated 04/17/21, documented at the time an eligible resident is admitted into the hospice program, a hospice care plan for the management and palliation of the resident's illness would be developed in cooperation with the interdisciplinary team. The hospice care is a written document which included a written and detailed description of the services and supplies necessary to provide palliative care for the resident. Hospice shall furnish a copy of this plan for each resident at the time of hospice admission.

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F 849	Continued From page 34	F 849		

The "Meadowlark Hospice Folder," documented the resident received hospice services starting 12/17/21.

In an email communication received on 01/11/22, Administrative Staff D provided a "Hospice Care Plan," dated 01/10/22, which lacked instructions directing what services, equipment, or medication would be provided to R21.

On 01/04/21 at 12:10 PM, R21 sat in a chair at the dining room table, with no signs of pain, and independently ate his noon meal with staff seated by him encouraging him to eat.

On 01/10/22 at 09:53 AM, Certified Nurse Aide (CNA) M stated she provided R21 the same cares that she would provide other residents on a daily basis. CNA M stated she had not seen a hospice aide but had seen a hospice nurse come and visit the resident, and the hospice nurse had not relayed anything regarding cares for R21 to her.

On 01/05/22 at 12:16 PM, Social Service Staff X stated he oversaw completing R21's care plan and verified R21 was lacking a section regarding hospice services.

On 01/10/22 at 09:00 AM, Administrative Nurse D stated the facility did not have a hospice care plan for R21. Administrative Nurse D stated she never knows when hospice staff are coming to the facility.

The facility's undated "Hospice Services" policy documented an interdisciplinary care plan would be completed which integrates the care and

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F 849	Continued From page 35 services provided by the facility and the hospice provider. The facility failed to establish and document routine communication between the hospice provider and facility staff which included a plan of care available to facility staff directing what services, equipment, or medication were provided to R21, placing him at risk for delayed or inadequate cares due to lack of communication and/or collaberation between facility staff and hospice care providers.	F 849		