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	175422	A. BUILDING _____ B. WING _____	C 11/23/2021

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 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00167222. The 2567 was electronically sent to the facility on 11/29/21.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The	F 609		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/29/2021

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.

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sample included three residents with one reviewed for injury of unknown origin. Based on record review and interview, the facility failed to identify and report to the state agency an allegation of abuse and/or neglect for cognitively impaired Resident (R) 1 who had bruising of unknown origin to her face and eye.

Findings included:

- R1's "Physician Order Sheet," dated 09/28/21, documented diagnoses of cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), and cognitive communication deficit.

The "Quarterly Minimum Data Set" (MDS), dated 09/17/21, documented R1 was rarely or never understood and was severely cognitively impaired. The MDS recorded R1 required extensive assistance of one to two staff for all activities of daily living (ADLs).

The "Activities of Daily Living Care Area Assessment" (CAA), dated 11/30/20, documented R1 required extensive to total assist with activities of daily living, was non-ambulatory and required a total (mechanical) lift for transfers.

The "Skin Integrity Care Plan," revised 11/17/21, directed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface and to ensure a foam cushion is on the bars of the Hoyer lift (an assistive mechanical device used to transfer residents from one place to another) in

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case the bar bumped the resident.

The "Nurse's Note," dated 11/16/21, documented a bruise and a bump on the right mid eyebrow. There was no injury the previous day shift and no injury reported by the night shift. The note further documented R1 bruised easily, took a blood thinner daily, and staff were educated to be careful during transfers.

The "Nurse's Note," dated 11/17/21 at 01:21 AM, documented R1 had a dark purple bruise around her right eye.

The "Nurse's Note," dated 11/17/21 at 09:29 AM, documented R1 had a dark purple bruise around her right eye and down the right side of her face.

On 11/23/21 at 09:45 AM, Certified Nurses Aide (CNA) M stated that she did not know how the injury to R1 occurred. She saw the bump and bruising to her head the morning of 11/16/21. She stated that when she and another CNA had gotten the resident up that morning with the Hoyer lift they did not hit her head. CNA M stated they assumed the injury had occurred from the bar of the Hoyer lift hitting the resident on the right side of her head..

On 11/23/21 at 09:50 AM, CNA N stated that she was on shift the morning the bruise was found to the right side of R1's head. She stated that she had gone into the resident's room first thing that morning and changed her and dressed her lower body and did not see any bruising or injury at that time. She stated she did not know about the injury until later that morning when the other CNAs told her about it. She stated that staff assumed that the resident had been hit with the

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Hoyer lift bar to cause the bruising to her right eye.

On 11/23/21 at 11:10 AM, CNA P stated that she had been on shift the evening of 11/15/21 and had not noticed any injury or bruising to R1 that evening. She stated that she and another CNA had transferred the resident that evening from her wheelchair to bed safely and per facility policy and no injury had occurred during the transfer.

On 11/23/21 at 11:15 AM, CNA Q stated that she had been on the evening shift of 11/15/21 and had assisted the resident back to bed with another CNA and had been running the lift. She did not see any injury occur to the resident during the transfer. She did not see and injury to the resident's face.

On 11/23/21 at 11:20 AM, CNA MM stated that he had worked the night shift at the facility from the evening of 11/15/21 to the morning of 11/16/21. He stated that he and the nurse had performed changing and turning every two hours and that he had not seen any injury to the resident's face. CNA MM stated R1 laid in bed all night surrounded by pillows all night long.

On 11/23/21 at 11:40 AM, Administrative Nurse D stated that she had investigated the injury of unknown origin obtained by R1 and had no clear evidence as to what had happened to cause the injury. She stated that she assumed that the resident had been hit with the Hoyer lift bar at some point and it was not relayed to the nursing staff and staff were not owning up to the incident . Administrative Nurse D stated she had not called the injury of unknown origin into the state agency because the primary care provider was not

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concerned about the injury, the resident was on blood thinner and there were no broken bones.

The facility's undated "Investigating Injuries of Unknown Origin" policy documented an injury shall be classified as an injury of unknown origin when both of the following conditions are met:
1. The elder is unable to explain how the injury occurred or the injury was not observed by an employee or visitor and;
2. The injury is suspicious because of the extent or location of the injury is in an area not vulnerable to trauma or the number of injuries observed at a particular time or incidences of injury that occurred over time cannot be explained.
Injuries of unknown causes will be investigated to determine if abuse or neglect could be a contributing factor. Team members will report the presence of bruising, and /or skin tears on elders to a neighborhood nurse immediately.
Un-witnessed falls and other accidents that were not observed by team members, another elder, or a visitor and the elder is unable to report what happened will be investigated. A nurse will evaluate the possible causes for the injuries and determine if the injuries could be the result of mistreatment or neglect. If the cause of the injury cannot be determined, the incident will be reported to the Director of Nursing and the Administrator immediately. An incident report will be completed and an investigation will be performed to identify the cause of injury. All incidents of injuries of unknown causes will be referred to the Quality Assurance Performance Improvement Committee for further investigation of root causes.

The facility's undated "Hoyer Lift" policy

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F 609	Continued From page 5 documented residents of this facility who have been assessed as unable to bear any weight will be transferred safely with use of a Full Body Hoyer lift. The facility failed to report R1's injury of unknown origin to the state agency, placing the resident at risk for ongoing abuse, neglect, or mistreatment.	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 29 residents. The sample included three residents with one reviewed for injury of unknown origin. Based on record review and interview, the facility failed to provide an environment safe from accidents/hazards for Resident (R) 1. This deficient practice placed R1 at increased risk for injuries related to accidents and/or hazards. Findings included: - R1's "Physician Order Sheet," dated 09/28/21, documented diagnoses of cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiparesis (muscular weakness of one half of	F 689		

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the body), hemiplegia (paralysis of one side of the body), and cognitive communication deficit.

The "Quarterly Minimum Data Set" (MDS), dated 09/17/21, documented R1 was rarely or never understood and was severely cognitively impaired. The MDS recorded R1 required extensive assistance of one to two staff for all activities of daily living (ADLs).

The "Activities of Daily Living Care Area Assessment" (CAA), dated 11/30/20, documented R1 required extensive to total assist with ADLs, was non-ambulatory and required a total (mechanical) lift for transfers.

The "Skin Integrity Care Plan," revised 11/17/21, directed staff to use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface and to ensure a foam cushion was on the bars of the Hoyer lift (an assistive mechanical device used to transfer residents from one place to another) in case the bar bumps the resident.

The "Nurse's Note," dated 11/16/21, documented a bruise and a bump on the right mid eyebrow. There was no injury the previous day shift and no injury reported by the night shift. The note further documented the resident bruised easily, took a blood thinner daily, and educated staff to be careful during transfers.

The "Nurse's Note," dated 11/17/21 at 01:21 AM documented R1 had a dark purple bruise around her right eye.

The "Nurse's Note," dated 11/17/21 at 09:29 AM documented R1 had a dark purple bruise around

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her right eye and down the right side of her face.

On 11/23/21 at 09:45 AM, Certified Nurses Aide (CNA) M stated that she did not know how the injury to R1 occurred. She saw the bump and bruising to her head the morning of 11/16/21. She stated that when she and another CNA got the resident up that morning with the Hoyer lift they did not hit her head. CNA M stated staff assumed the injury had occurred from the bar of the Hoyer lift hitting the resident on the right side of her head. CNA M stated after the injury was found, there was no education or training given regarding use of the lift.

On 11/23/21 at 09:50 AM, CNA N stated she was on shift the morning the bruise was found to the right side of R1's head. She stated she had gone into the resident's room first thing that morning and changed her and dressed her lower body and did not see any bruising or injury at that time. She stated she did not know about the injury until later that morning when the other CNAs told her about it. She stated that staff assumed the resident had been hit with the Hoyer lift bar to cause the bruising to her right eye. CNA N stated there had been no education presented to staff regarding safe lift training after the injury was found.

On 11/23/21 at 09:55 AM, CNA O stated that she had been on shift the morning that the bruise was found to the right side of R1's face. She stated that she and another CNA had gone into the resident's room to get her up for breakfast. They got her up with the Hoyer lift and did not notice any bruising until after the resident was up in the wheelchair. She denied that there had been any incident while transferring the resident from the bed to the wheelchair. She stated staff assumed

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the resident had been hit with the bar of the Hoyer lift causing the injury. CNA O stated that she had not received any training regarding safety while using the Hoyer lift.

On 11/23/21 at 11:10 AM, CNA P stated that she had been on shift the evening of 11/15/21 and had not noticed any injury or bruising to R1 that evening. She stated that she and another CNA had transferred the resident that evening from her wheelchair to bed safely and per facility policy and no injury had occurred during the transfer. She stated that she had not received any training regarding safe use of the Hoyer lift with transfers.

On 11/23/21 at 11:15 AM, CNA Q stated that she had been on the evening shift of 11/15/21 and had assisted the resident back to bed with another CNA and had been running the lift. She did not see any injury occur to the resident during the transfer. She did not see and injury to the resident's face. CNA Q further stated she had not received any training regarding safe Hoyer lift transfers.

On 11/23/21 at 11:20 AM, CNA MM stated that he had worked the night shift at the facility from the evening of 11/15/21 to the morning of 11/16/21. He stated that he and the nurse had performed changing and turning every two hours and that he had not seen any injury to the resident's face. CNA MM stated R1 laid in bed all night surrounded by pillows all night long. He further stated that he had not received any training regarding safe full lift transfers.

On 11/23/21 at 11:40 AM, Administrative Nurse D, stated that she had investigated the injury of unknown origin obtained by R1 and had no clear

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evidence as to what had happened to cause the injury. She stated that she assumed that the resident had been hit with the Hoyer lift bar at some point and it was not relayed to the nursing staff and staff were not owning up to the incident happening. Administrative Nurse D stated she had not called the injury of unknown origin into the State of Kansas because the primary care provider was not concerned about the injury, the resident was on blood thinner and there were no broken bones. Administrative Nurse D stated the facility had not done any formal Hoyer lift training in regard to safety during transfers, but they had put foam pool noodles on all of the Hoyer lifts to provide extra cushion if something like this should happen again.

The facility's undated "Investigating Injuries of Unknown Origin" policy documented an injury shall be classified as an injury of unknown origin when both of the following conditions are met:
1. The elder is unable to explain how the injury occurred or the injury was not observed by an employee or visitor and;
2. The injury is suspicious because of the extent or location of the injury is in an area not vulnerable to trauma or the number of injuries observed at a particular time or incidences of injury that occurred over time cannot be explained.
Injuries of unknown causes will be investigated to determine if abuse or neglect could be a contributing factor. Team members will report the presence of bruising, and /or skin tears on elders to a neighborhood nurse immediately.
Un-witnessed falls and other accidents that were not observed by team members, another elder, or a visitor and the elder is unable to report what happened will be investigated. A nurse will

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evaluate the possible causes for the injuries and determine if the injuries could be the result of mistreatment or neglect. If the cause of the injury cannot be determined, the incident will be reported to the Director of Nursing and the Administrator immediately. An incident report will be completed and an investigation will be performed to identify the cause of injury. All incidents of injuries of unknown causes will be referred to the Quality Assurance Performance Improvement Committee for further investigation of root causes.

The facility's undated "Hoyer Lift " policy documented residents of this facility who have been assessed as unable to bear any weight will be transferred safely with use of a Full Body Hoyer lift.

The facility failed to provide an environment free from accident hazards for R1, who received an injury to the right side of her face which the facility determined was a result of being hit by the Hoyer lift bar. This placed R1 at increased risk for injuries related to accidents and /or hazards.