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 _____	07/11/2023

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, partial extended survey and complaint investigation for KS00180828. On 07/10/23 at 03:15 PM Administrative Staff A received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident(R) 41 and all full code residents. On 04/08/23 at 05:00 PM, Licensed Nurse (LN) G observed R41 with irregular respirations. At 05:10 PM, LN G checked on R41 again and identified R41 had no pulse or respirations. Without considering R41's code status or initiating CPR, LN G placed a call to R41's representative, who did not answer. LN G then called Administrative Nurse E who informed LN G that R41 was a "full code" and directed LN G to start CPR. At 05:22 PM, LN G activated 911 and then initiated CPR. The facility failed to ensure staff immediately initiated CPR upon identification of R41's cardiac arrest when staff delayed 12 minutes to place calls to resources other than 911. The delay placed R41 and all residents with a full code status in immediate jeopardy. The facility further failed to have a system in place to identify and ensure CPR certified staff were always present in the facility. On 07/10/23 the facility implemented the following corrective actions to address the immediacy. Staff received education on signs/identification of cardiac arrest. Staff educated on when to start CPR procedure including location of equipment. Staff educated on CPR Policy. CPR certification status of all direct care staff was	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/19/2023

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 _____	07/11/2023

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	Continued From page 1 assessed to ensure currently certified CPR staff were on duty at all times. DNR/Full Code status of all residents reviewed. Door identifiers on resident's doors checked for accuracy. Removal of the immediacy was verified during the onsite survey on 07/11/23. The scope and severity remained at the level of "G" to indicate the actual harm for R41. The 2567 was sent electronically on 07/19/23.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal	F 576		

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 _____	07/11/2023

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 576	Continued From page 2	F 576		

service, including the right to:
(i) Privacy of such communications consistent with this section; and
(ii) Access to stationery, postage, and writing implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.
(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 15 residents. Based on observation, record review and interview the facility failed to provide mail delivery to resident's in the facility on Saturday's.

Findings included:

- On 07/06/23 at 10:15AM, during a confidential meeting with five of the resident council members, they verbalized mail was not being delivered on Saturdays.

On 07/06/23 at 11:50AM, Social Service X verified mail was not delivered on Saturday to facility residents. Social Services X stated the mail was taken to the business office and then passed out to residents on Mondays.

The facility undated, "Resident Right's policy, stated the resident's in the facility have the right

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 _____	07/11/2023

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 576	Continued From page 3 to send and receive mail. The facility failed to distribute resident mail on Saturdays.	F 576		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 636		

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 _____	07/11/2023

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 636	Continued From page 4	F 636		

regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 15 residents. Based on record review and interviews, the facility failed to fully complete comprehensive Minimum Data Set (MDS) assessment Section V, Care Area Assessment Summary (CAA) for Resident (R) 7, R23, R3, R28, and R93 to include an analysis and rationale for care planning decisions. This placed these residents at risk for not accurately reflecting each resident's status and needs to develop an individualized comprehensive plan of

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 _____	07/11/2023

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 636	Continued From page 5	F 636		

care.

Findings included:

- R7's "Admission MDS" with assessment reference date (ARD) of 01/27/23 Section V Care Area Assessment (CAA) was not completed.

R23's "Annual MDS" with ARD of 11/02/22 Section V CAA was not completed.

R3's "Annual MDS" with ARD of 10/27/22 Section V CAA was not completed.

R28's "Admission MDS" with ARD of 02/07/23Section V CAA was not completed.

R93's "Admission MDS" with ARD of 06/12/23 Section V CAA was not completed.

The "Resident Assessment Instrument Manual" version 3.0 states, the CAA process provides a framework for guiding the review of triggered areas, and clarification of a resident's functional status and related causes of impairments. It also provides a basis for additional assessment of potential issues, including related risk factors. The assessment of the causes and contributing factors gives the interdisciplinary team (IDT) additional information to help them develop a comprehensive plan of care.

On 07/11/23 at 10:00AM, Administrative Staff A verified the five residents' MDS CAAs were not completed.

Upon request the facility did not provide a policy for Minimum Data Set Completion.

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 _____	07/11/2023

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 636	Continued From page 6 The facility failed to complete comprehensive MDS Section V, CAA for R7, R23, R3, R28, and R93 which placed these residents at risk for not accurately reflecting each resident's status and needs, to develop an individualized comprehensive plan of care.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: The facility had a census of 36 resident. The sample included 15 residents. Based on observation, record review and interview the facility failed to complete a "Significant Change Minimum Data Set (MDS)" for Resident (R)25 who had a change in activities of daily living (ADL). This placed the resident at risk for unidentified care needs. Findings included: - R25's Electronic Medical Record (EMR) documented he had diagnoses of unspecified dementia with behavioral disturbance (impaired	F 637		

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 _____	07/11/2023

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 637	Continued From page 7	F 637		

cognition, anxiety, agitation), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe), convulsions (muscles contract and relax quickly and cause uncontrolled shaking of the body), and Parkinson's disease (a disorder of the central nervous system that affects movement, often causing tremors).

R25's "Quarterly Minimum Data Set" (MDS), dated 05/30/23, documented the resident was severely cognitively impaired. The MDS documented R25 transferred and ambulated independently and required minimal assistance with transfers.

R25's "At Risk for Falls Care Plan," dated 05/30/23, instructed R25 required oversight when ambulating for safety.

Review of the "Activities of Daily Living" flow record revealed on 6/10/23 to 07/5/23 R25 required extensive assist with transfers, bed mobility, dressing, grooming, personal hygiene and eating.

On 07/05/23 at 10:00AM, observation revealed R25 sat in a wheelchair near the nurse's room.

On 07/06/23 at 09:20AM, observation revealed Certified Nurse Aide (CNA) M pushed R25 in his wheelchair to his room. Further observation revealed CNA N entered the room placed the wheelchair beside the bed, and then placed a gait belt around the resident's waist. CNA M stood on the left of the resident while CNA N stood on the right side of the resident facing him. Each CNA placed their hand under each arm of the resident and lifted him from the wheelchair to his bed,

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 _____	07/11/2023

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 637	Continued From page 8	F 637		

while R25 bent both of his legs as they swung him around and placed him on the side of the bed.

On 07/10/23 at 08:10AM, observation revealed R25 lying in bed on his back. Further observation revealed CNA O and CNA P in the resident's room. CNA O assisted the resident to turning in bed on his right side while CNA P placed a gait belt under him, CNA P then lifted the resident's legs and had him seated on the side of his bed, while CNA O placed the wheelchair by the bed. CNA P attached the gait belt around his waist. CNA O asked the resident to stand up from the bed and to sit in the wheelchair. CNA P and CNA O placed their hands under the residents arms, not using the gait belt, and lifted the resident to the wheelchair. During the transfer, the resident did not bear weight and had his legs bent.

On 07/06/23 at 09:40AM, CNA M verified the resident did not bear weight and required two staff to assist him with transfers.

On 07/06/23 at 10:30AM, Licensed Nurse (LN) G verified R25 currently required extensive assist with transfers, bed mobility, dressing, grooming, personal hygiene and eating.

On 07/06/23 at 02:40PM, Speech Therapist (ST) GG verified R25's Parkinson's disease progression led to his decline in health status and ADL.

The "Resident Assessment Instrument Manual" version 3.0 states, when a resident has a change in condition a Significant Change Minimum Data Set (MDS) should be completed with the changes for a resident, and will not normally resolve itself

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 _____	07/11/2023

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 637	Continued From page 9 without intervention by staff or by implementing standard disease-related clinical interventions. On 07/11/23 at 10:00AM, Administrative Staff A verified a Significant Change Minimum Data Set was not completed for R25. The "Resident Assessment Instrument Manual" version 3.0 states, when a resident has a change in condition a Significant Change Minimum Data Set (MDS) should be completed with the changes for a resident, and will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. Upon request the facility did not provide a policy for Minimum Data Set Significant change. The facility failed to complete a Significant Change MDS for R25 who had a significant change on ADL status due to disease progression which was not expected to resolve. This placed the resident at risk for inappropriate care and services.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		

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 _____	07/11/2023

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 656	Continued From page 10	F 656		

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 15 residents with two reviewed for accidents. Based on observation, record review, and interview the facility failed failed to

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 _____	07/11/2023

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 656	Continued From page 11	F 656		

develop a plan of care with meaningful fall prevention interventions for Resident (R)29 who had two falls. This placed the resident at increased risk for falls and fall-related injury.

Findings included:

- R29's Electronic Medical Record (EMR) documented R29 had diagnoses of intellectual disability, localized (one area) edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and venous insufficiency (a condition in which the flow of blood through the veins is blocked, causing blood to pool in the legs).

R29's "Quarterly Minimum Data Set" (MDS), dated 05/15/23, documented R29 had a Brief Interview of Mental Status (BIMS) of 10, which indicated moderately impaired cognition. The MDS documented R29 required extensive staff assistance with activities of daily living (ADLs) except supervision with eating. The MDS documented the resident had no fall since prior assessment. The MDS documented R29's balance not steady and he was only able to stabilize with staff assistance.

R29's "Care Plan," revised 06/07/23, lacked a section regarding falls with instructions to staff regarding interventions to prevent R29 from falling.

The "Morse Fall Scale," dated 07/04/23, documented R29 had a score of 75, which indicated a high risk for falling.

The 05/29/23 at 07:55 PM "Incident Note," documented staff heard R29 yelling for help.

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 _____	07/11/2023

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 656	Continued From page 12	F 656		

When staff arrived to R29's room, the resident sat on his left buttock on the floor. His recliner was tipped all the way over, but not on top of the resident. The note documented R29 was previously in the recliner. The recliner was in the highest standing position. R29 stated he was getting the cat out from behind his recliner and fell. The note documented R29 had no injuries.

The 07/02/2023 at 02:21 "Incident Note," documented at 01:45 PM the nurse heard a crash in R29's room, and found R29 laying on the floor between the bed and the wall on his left side. The note documented R29 had a 2.5 centimeter bloody skin tear above his left eye. The note documented R29 had pain above the left eye rated at three, and no other injuries.

R29's EMR lacked evidence causative factors related to the falls were identified and lacked interventions in response to the falls to avoid future falls.

On 07/1/23 at 02:15 PM, observation revealed Certified Medication Aide (CMA) R assisted R29 with a gait belt to transfer from a wheelchair to a recliner in his room. CMA R placed her hands on the back of R29's gait belt and cued him on steps to take to transfer. Observation revealed R29 was unsteady on his feet.

On 07/10/23 at 09:13 AM, Administrative Nurse D verified there were no revisions made to attempt to prevent R29 from falling. Administrative nurse D verified there should be fall interventions in place for R29.

Upon request the facility failed to provide a care plan policy.

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 _____	07/11/2023

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 656	Continued From page 13 The facility failed to develop a care plan which addressed falls for R29, with interventions for staff to follow to prevent R29 from falling. This placed R29 at risk for increased risk for falls and fall related injury.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

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 _____	07/11/2023

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 657	Continued From page 14	F 657		

The facility had a census of 36 residents. The sample included 15 residents. Based on observation, record review and interview the facility failed to revise Resident (R) 25's care plan for accidents. This placed the resident at risk for injury related to uncommunicated or unmet care needs.

Findings included:

- R25's Electronic Medical Record (EMR) documented he had diagnoses of unspecified dementia with behavioral disturbance (impaired cognition, anxiety, agitation), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe), convulsions (muscles contract and relax quickly and cause uncontrolled shaking of the body), and Parkinson's disease (a disorder of the central nervous system that affects movement, often causing tremors).

R25's "Quarterly Minimum Data Set" (MDS), dated 05/30/23, documented the resident was severely cognitively impaired. The MDS documented R25 transferred and ambulated independently and required minimal assistance with transfers.

R25's "At Risk for Falls Care Plan," dated 05/30/23, instructed staff R25 required oversight when ambulating for safety. The care plan lacked interventions for transferring the resident.

The "Fall Risk Assessment," dated 05/30/23, documented R25 was at risk for falls.

On 07/05/23 at 10:00AM, observation revealed R25 sat in a wheelchair near the nurse's room.

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 _____	07/11/2023

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 657	Continued From page 15	F 657		

On 07/06/23 at 09:20AM, observation revealed Certified Nurse Aide (CNA) M pushed R25 in his wheelchair to his room. Further observation revealed CNA N entered the room placed the wheelchair beside the bed, and then placed a gait belt around the resident's waist. CNA M stood on the left of the resident while CNA N stood on the right side of the resident facing him. Each CNA placed their hand under each arm of the resident and lifted him from the wheelchair to his bed, while R25 bent both of his legs as they swung him around and placed him on the side of the bed.

On 07/10/23 at 08:10AM, observation revealed R25 lying in bed on his back. Further observation revealed CNA O and CNA P in the resident's room. CNA O assisted the resident to turning in bed on his right side while CNA P placed a gait belt under him, CNA P then lifted the resident's legs and had him seated on the side of his bed, while CNA O placed the wheelchair by the bed. CNA P attached the gait belt around his waist. CNA O asked the resident to stand up from the bed and to sit in the wheelchair. CNA P and CNA O placed their hands under the residents arms, not using the gait belt, and lifted the resident to the wheelchair. During the transfer, the resident did not bear weight and had his legs bent.

On 07/06/23 at 09:40AM, CNA M verified the resident did not bear weight during the transfer from wheelchair to bed and stated it was difficult to transfer the resident from his wheelchair to the bed.

On 07/10/23 at 08:30AM, CNA O verified the resident did not bear weight during the transfer

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 _____	07/11/2023

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 657	Continued From page 16 from the bed to wheelchair and said it was difficult to transfer the resident from bed to wheelchair. On 07/11/23 at 08:30AM, Administrative Nurse D verified the transfer of R25 was not done safely and said other measures needed to be implemented to ensure safety when transferring R25 with care plan update and revision. Upon request the facility did not provide a policy for care plan revision. The facility failed to review and revise R25's care plan for transfers placing the resident at risk for injury and inappropriate care related to uncommunicated care needs.	F 657		
F 678 SS=K	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 15 residents, with one closed record for death, reviewed. Based on record review and interview, the facility failed to ensure staff provided cardiopulmonary resuscitation (CPR) to Resident (R) 41, who desired resuscitative measures indicated by his full code status (code status determination for residents who wish to receive CPR). On 04/08/23 at 05:00 PM, Licensed Nurse (LN) G observed R41 with irregular respirations. At 05:10 PM, LN G checked	F 678		

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 _____	07/11/2023

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 678	Continued From page 17	F 678		

on R41 again and identified R41 had no pulse or respirations. Without considering R41's code status or initiating CPR, LN G placed a call to R41's representative, who did not answer. LN G then called Administrative Nurse E who informed LN G that R41 was a "full code" and directed LN G to start CPR. At 05:22 PM, LN G activated 911 and then initiated CPR. The facility failed to ensure staff immediately initiated CPR upon identification of R41's cardiac arrest when staff delayed 12 minutes to place calls to resources other than 911. The delay placed R41 and all residents with a full code status in immediate jeopardy. The facility further failed to have a system in place to identify and ensure CPR certified staff were always present in the facility.

Findings included:

- R41's Electronic Medical Record (EMR) documented R41 had diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), polyneuropathy (nerve disease, that affects many nerves), and dependence on wheelchair for mobility.

R41's "Quarterly Minimum Data Set" (MDS), dated 01/09/23, documented R41 had a Brief Interview of Mental Status (BIMS) score 14, which indicated intact cognition. The MDS documented R41 required extensive staff assistance with activities of daily living (ADL) except eating.

R41's "Full Code Care Plan," revised 02/28/23, documented R41 desired to be a full code, and instructed staff to perform CPR in a code situation.

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 _____	07/11/2023

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 678	Continued From page 18	F 678		

The "Physician Order," dated 09/20/22, instructed staff R41 was full code status.

The 04/08/23 at 12:15 PM, "Nurse's Note," documented R41 had an episode that morning where he had tremors (uncontrolled shaking) and was diaphoretic (sweaty). The note documented R41 had a blood pressure of 133/86 millimeters of Mercury (mmHg), pulse of 78 beats per minute, respirations of 20 per minute, and oxygen saturation of 90 percent (%) on room air. R41 ate a little breakfast then went back to bed. The note documented staff elevated the head of his bed.

The 04/08/23 at 06:37 PM, "Nurse's Note" documented LN G entered R41's room at 05:00 PM and observed R41's respiration were rapid, then left the room. The note documented at 05:10 PM, LN G returned to R41's room and noticed R41 had oral secretions coming out of his mouth. LN G retrieved a cool cloth and washed around R41's mouth and realized R41 was not breathing. The note documented LN G checked R41's pulse and respiration at that time and noted both pulse and respirations were absent. LN G also noticed mottling (blotchy, red-purplish marbling of the skin, due to lack of blood flow) of R41's lower extremities. LN G then attempted to phone R41's representative who did not answer. LN G left a message for R41's representative then phoned Administrative Nurse E. Administrative Nurse E informed LN G that R41 was a full code and instructed LN G to call 911 and start chest compression. The note further documented LN G called 911 at 05:22 PM, then started CPR on R41.

On 07/10/23 at 12:54 PM, LN H stated a stop

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 _____	07/11/2023

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 678	Continued From page 19	F 678		

sign sticker below the name plate outside the resident's doors, indicated the resident's code status; a red (sticker) indicated a do not resuscitate status (DNR) and green (sticker) indicated a full code status. LN H stated the residents' code status was also in the medical record.

On 07/10/23 at 12:58 PM, LN G verified she had not checked R41's code status on the stop sign sticker by R41's name tag outside his door. LN G stated she just assumed R41 was a DNR because so many of the residents who resided in the facility were DNRs. She stated she did not even think about starting CPR.

On 07/10/23 at 01:33 PM, Administrative Nurse D stated residents code status was indicated by a colored tags outside their room door by their name. Administrative Nurse D stated she expected staff to initiate CPR immediately if the resident was a full code. Administrative Nurse D said if staff did not know a resident's code status, staff should yell for help and immediately start CPR.

On 07/10/23 at 01:49 PM, Administrative Nurse D stated the facility had no documentation regarding in-service training or re-education on CPR procedure and the facility did not provide CPR training for nurse aides or medication aides. Administrative Nurse D stated the facility did not have a list of staff certified in CPR.

On 07/10/23 at 02:45 PM, LN G verified she had let her CPR certification lapse in January 2023.

On 07/10/23 at 04:00PM, Administrative Nurse D verified there were five residents currently in 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 _____	07/11/2023

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 678	Continued From page 20	F 678		

facility with a full code status.

The facility's "CPR Policy," undated, documented any resident designating a desire for no resuscitation and is found to be without vital signs would have a small red stop sign sticker placed on the name tag of the door of the resident. The policy documented CPR would be initiated when cardiac arrest occurs for a resident who has requested CPR in the advance directive, when a resident has not formulated an advance directive, and when the resident does not have a valid "DNR order" from a licensed physician or professional practitioner.

The facility failed to ensure staff immediately initiated CPR to R41, who desired resuscitative measures indicted by his full code status when staff delayed 12 minutes to place calls to resources other than 911. The delay placed R41 and five other residents with a full code status in immediate jeopardy.

On 07/10/23 the facility implemented the following corrective actions to address the immediacy.
Staff received education on signs/identification of cardiac arrest.
Staff educated on when to start CPR procedure including location of equipment.
Staff educated on CPR Policy.
CPR certification status of all direct care staff was assessed to ensure currently certified CPR staff were on duty at all times.
DNR/Full Code status of all residents reviewed.
Door identifiers on resident's doors checked for accuracy.

Removal of the immediacy was verified during the onsite survey on 07/11/23. The scope and

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 _____	07/11/2023

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 678	Continued From page 21 severity remained at the level of "G" to indicate the actual harm for R41.	F 678		
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 36 residents. The sample included 15 residents. Based on observation, record review, and interview the facility failed to provide adequate assistance and safety with transfers for Resident (R) 25 and failed to identify and implement interventions to prevent falls for R29 who had two falls. This placed the residents at risk for future falls and related injury. Findings included: - R25's Electronic Medical Record (EMR) documented he had diagnoses of unspecified dementia with behavioral disturbance (impaired cognition, anxiety, agitation), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe), convulsions (muscles contract and relax quickly and cause uncontrolled shaking of the body), and Parkinson's disease (a disorder of the central nervous system that affects movement, often causing tremors).	F 689		

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 _____	07/11/2023

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 689	Continued From page 22	F 689		

R25's "Quarterly Minimum Data Set" (MDS), dated 05/30/23, documented the resident was severely cognitively impaired. The MDS documented R25 transferred and ambulated independently and required minimal assistance with transfers.

R25's "At Risk for Falls Care Plan," dated 05/30/23, instructed staff R25 required oversight when ambulating for safety.

The "Fall Risk Assessment," dated 05/30/23, documented R25 was at risk for falls.

On 07/05/23 at 10:00AM, observation revealed R25 sat in a wheelchair near the nurse's room.

On 07/06/23 at 09:20AM, observation revealed Certified Nurse Aide (CNA) M pushed R25 in his wheelchair to his room. Further observation revealed CNA N entered the room placed the wheelchair beside the bed, and then placed a gait belt around the resident's waist. CNA M stood on the left of the resident while CNA N stood on the right side of the resident facing him. Each CNA placed their hand under each arm of the resident and lifted him from the wheelchair to his bed, while R25 bent both of his legs as they swung him around and placed him on the side of the bed.

On 07/10/23 at 08:10AM, observation revealed R25 lying in bed on his back. Further observation revealed CNA O and CNA P in the resident's room. CNA O assisted the resident to turning in bed on his right side while CNA P placed a gait belt under him, CNA P then lifted the resident's legs and had him seated on the side of his bed,

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 _____	07/11/2023

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 689	Continued From page 23	F 689		

while CNA O placed the wheelchair by the bed. CNA P attached the gait belt around his waist. CNA O asked the resident to stand up from the bed and to sit in the wheelchair. CNA P and CNA O placed their hands under the residents arms, not using the gait belt, and lifted the resident to the wheelchair. During the transfer, the resident did not bear weight and had his legs bent.

On 07/06/23 at 09:40AM, CNA M verified the resident did not bear weight during the transfer from wheelchair to bed and stated it was difficult to transfer the resident from his wheelchair to the bed.

On 07/10/23 at 08:30AM, CNA O verified the resident did not bear weight during the transfer from the bed to wheelchair and said it was difficult to transfer the resident from bed to wheelchair.

On 07/11/23 at 08:30AM, Administrative Nurse D verified the transfer of R25 was not done safely and said other measures needed to be implemented to ensure safety when transferring R25.

Upon request the facility did not provide a policy for accidents, transfers.

The facility failed to transfer R25 in a safe manner, placing him at risk for injury.
- R29's Electronic Medical Record (EMR) documented R29 had diagnoses of intellectual disability, localized (one area) edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and venous insufficiency (a condition in which the flow of blood through the veins is blocked, causing blood to pool in the legs).

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 _____	07/11/2023

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 689	Continued From page 24	F 689		

R29's "Quarterly Minimum Data Set" (MDS), dated 05/15/23, documented R29 had a Brief Interview of Mental Status (BIMS) of 10, which indicated moderately impaired cognition. The MDS documented R29 required extensive staff assistance with activities of daily living (ADLs) except supervision with eating. The MDS documented the resident had no fall since prior assessment. The MDS documented R29's balance was not steady and he was only able to stabilize with staff assistance.

R29's "Care Plan," revised 06/07/23, lacked a section regarding falls with instructions to staff regarding interventions to prevent R29 from falling.

The "Morse Fall Scale," dated 07/04/23, documented R29 had a score of 75, which indicated a high risk for falling.

The 05/29/23 at 07:55 PM "Incident Note," documented staff heard R29 yelling for help. When staff arrived to R29's room, the resident sat on his left buttock on the floor. His recliner was tipped all the way over, but not on top of the resident. The note documented R29 was previously in the recliner. The recliner was in the highest standing position. R29 stated he was getting the cat out from behind his recliner and fell. The note documented R29 had no injuries.

The 07/02/2023 at 02:21 "Incident Note," documented at 01:45 PM the nurse heard a crash in R29's room, and found R29 laying on the floor between the bed and the wall on his left side. The note documented R29 had a 2.5 centimeter bloody skin tear above his left eye. The note

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 _____	07/11/2023

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 689	Continued From page 25 documented R29 had pain above the left eye rated at three, and no other injuries. R29's EMR lacked evidence causative factors related to the falls were identified and lacked interventions in response to the falls to avoid future falls. On 07/1/23 at 02:15 PM, observation revealed Certified Medication Aide (CMA) R assisted R29 with a gait belt to transfer from a wheelchair to a recliner in his room. CMA R placed her hands on the back of R29's gait belt and cued him on steps to take to transfer. Observation revealed R29 was unsteady on his feet. On 07/10/23 at 09:13 AM, Administrative Nurse D verified there were no active intervention In place to attempt to prevent R29 from falling. Administrative nurse D verified there should be fall interventions in place for R29. Upon request the facility failed to provide a fall policy. The facility failed to identify causative factors and implement interventions for R29 when he had two falls, to prevent further falls. This placed the resident at increased risk for falls and fall related injury.	F 689		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726		

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 _____	07/11/2023

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 726	Continued From page 26	F 726		

practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 15 residents with one closed record for death reviewed. Based on record review and interview the facility failed to ensure licensed nurses possessed the knowledge and skills to provide cardiopulmonary resuscitation (CPR) for Resident (R) 41, who desired resuscitative measures indicated by his full code status. This placed the full code status residents at risk for receiving inadequate resuscitative measures.

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 _____	07/11/2023

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 726	Continued From page 27	F 726		

Findings included:

- R41's Electronic Medical Record (EMR) documented R41 had diagnoses of depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness), polyneuropathy (nerve disease, that affects many nerves), and dependence on wheelchair for mobility.

R41's "Quarterly Minimum Data Set" (MDS), dated 01/09/23, documented R41 had a Brief Interview of Mental Status (BIMS) score 14, which indicated intact cognition. The MDS documented R41 required extensive staff assistance with activities of daily living (ADLs) except supervision with eating.

R41's "Full Code Care Plan," revised 02/28/23, documented R41 desired to be a full code, and instructed staff to perform CPR in a code situation.

The "Physician Order," dated 09/20/22, instructed staff R41 was full code status.

The 04/08/23 at 12:15 PM, "Nurses' Note," documented R41 had an episode that morning where he had a lot of tremors (uncontrolled shaking) and was diaphoretic (sweaty). The note documented R41' had a blood pressure of 133/86 millimeters (mm) of Mercury (Hg), pulse of 78 beats per minute respirations of 20 per minute and oxygen saturation of 90 percent (%) on room air. R41 ate a little breakfast then went back to bed. The note documented staff elevated the head of his bed.

The 04/08/23 at 06:37 PM, "Nurses' Note"

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 _____	07/11/2023

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 726	Continued From page 28	F 726		

documented at 05:00 PM, LN G entered R41's room and observed R41's respiration were rapid then left the room. The note documented at 05:10 PM LN G returned to R41's room and noticed R41 had oral secretions coming out of his mouth. LN G retrieved a cool cloth and washed around R41's mouth and realized R41 was not breathing. The note documented LN G checked R41's pulse and respiration at that time and noted both pulse and respiration were absent. LN G also noticed mottling (blotchy, red-purplish marbling of the skin) of R41's lower extremities. LN G then attempted to phone R41's representative who did not answer. LN G left am message for R41's representative then phoned Administrative Nurse E. Administrative Nurse E informed LN G that R41 was a full code and instructed LN G to call 911 and start chest compression. The note further documented LN G called 911 at 05:22 PM then started CPR on R41.

On 07/10/23 at 12:54 PM, LN H stated residents' code status was indicated by a stop sign sticker below the name plate outside their doors; a red indicated a do not resuscitate stats (DNR) and green indicated a full code. LN H stated the residents' code status was also in the medical record.

On 07/10/23 at 12:58 PM, LN G verified she had not checked R41's code status on the stop sign sticker by R41's name tag outside his door. LN G stated she just assumed R41 was a DNR because so many of the residents who resided in the facility were DNRs. She stated she did not even think about starting CPR.

On 07/10/23 at 02:45 PM, LN G verified she had

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 _____	07/11/2023

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 726	Continued From page 29	F 726		

let her CPR certification lapse in January 2023.

On 07/10/23 at 01:33 PM, Administrative Nurse D stated residents code status was indicated by a colored tags outside their room door by their name. Administrative Nurse D stated she expected staff to initiate CPR immediately if the resident was a full code. Administrative Nurse D said if staff did not know a resident's code status, staff should yell for help and immediately start CPR.

On 07/10/23 AT 01:49 PM, Administrative Nurse D stated the facility had no documentation regarding in-service training or re-education on CPR procedure and the facility did not provide CPR training for nurse aides or medication aides. Administrative Nurse D stated the facility did not have a list of staff certified in CPR.

On 07/10/23 at 04:00PM, Administrative Nurse D verified there were five residents currently in the facility with a full code status.

The facility's "CPR Policy," undated, documented any resident designating a desire for no resuscitation and is found to be without vital signs would have a small red stop sign sticker placed on the name tag of the door of the resident. The policy documented CPR would be initiated when cardiac arrest occurs for a resident who has requested CPR in the advance directive, when a resident has not formulated an advance directive, and when the resident does not have a valid "DNR order" from a licensed physician or professional practitioner.

The facility failed to ensure licensed nurses possessed the knowledge and skills to provide

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 _____	07/11/2023

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 726	Continued From page 30 CPR for R41, who desired resuscitative measures indicated by his full code status. This placed the R41 and all residents with full code status at risk for receiving inadequate resuscitative measures.	F 726		
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. §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.	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 _____	07/11/2023

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 756	Continued From page 31	F 756		

§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 36 residents. The sample included 15 residents, with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to implement a process to acknowledge and respond to the Consultant Pharmacist (CP) recommendation for an appropriate indication for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R) 25. This deficient practice placed the resident at risk for unnecessary psychotropic (alters mood or thought) medications.

Findings included:

- R25's Electronic Medical Record (EMR) documented he had diagnoses of unspecified dementia with behavioral disturbance (impaired cognition, anxiety, agitation), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe), convulsions (muscles contract and relax quickly and cause uncontrolled shaking of the body), and Parkinson's disease (a disorder of the central nervous system that affects movement, often causing tremors).

R25's "Quarterly Minimum Data Set" (MDS),

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 _____	07/11/2023

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 756	Continued From page 32	F 756		

dated 05/30/23, documented the resident was severely cognitively impaired. The MDS documented R25 transferred and ambulated independently and required minimal assistance with transfers.

The "Behavior Care Plan," dated 05/30/23, documented the resident was aggressive during care. The care plan directed the staff to use a quiet approach when caring for the resident.

The "Antipsychotic Use Care Plan," dated 05/30/23, documented for staff to monitor for side effects which included nausea, vomiting, diarrhea, motor problems, blood sugar & cholesterol changes, increased mortality rate in dementia, and tardive dystonia (abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk).

The "Physician Order" dated 02/28/23 directed the staff to administer Risperdal (antipsychotic) 0.25 milligrams (mg) PO (by mouth) daily for aggression.

The CP's monthly medication review documentation for R25 revealed the CP identified and reported the need for an appropriate diagnosis for R25's Risperdal on the monthly reviews completed on 03/15/23, 04/12/23, 05/10/23, and 06/07/23.

Review of R25's clinical record lacked evidence the facility and acknowledged and responded to the CP recommendations.

On 07/05/23 at 10:00AM, observation revealed R25 sat in a wheelchair near the nurse's room.

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 _____	07/11/2023

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 756	Continued From page 33 On 07/11/23 at 08:30AM, Administrative Nurse D verified R25 received a routine antipsychotic medication for aggression. Administrative Nurse D verified the diagnosis for the use of the medication was not appropriate and was unsure if the pharmacy recommendations had been returned from the physician. Upon request the facility did not provide a policy for psychotropic medication use. The facility failed to implement a process to acknowledge and respond to the CP recommendation for an appropriate indication for the continued use of an antipsychotic or R25. This deficient practice placed the resident at risk for unnecessary psychotropic medications.	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, 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	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 _____	07/11/2023

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 758	Continued From page 34	F 758		

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 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 36 residents. The sample included 15 residents, with five reviewed for unnecessary medications. Based on observation, record review and interview, the facility failed to ensure an appropriate indication, or a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and

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 _____	07/11/2023

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 758	Continued From page 35	F 758		

risk versus benefits for the continued use of an antipsychotic (class of medications used to treat mental disorder characterized by a gross impairment in reality testing) for Resident (R) 25's This deficient practice placed the resident at risk for unnecessary psychotropic (alters mood or thought) medications.

Findings included:

- R25's Electronic Medical Record (EMR) documented he had diagnoses of unspecified dementia with behavioral disturbance (impaired cognition, anxiety, agitation), chronic obstructive pulmonary disease (COPD-a group of lung diseases that block airflow and make it difficult to breathe), convulsions (muscles contract and relax quickly and cause uncontrolled shaking of the body), and Parkinson's disease (a disorder of the central nervous system that affects movement, often causing tremors).

R25's "Quarterly Minimum Data Set" (MDS), dated 05/30/23, documented the resident was severely cognitively impaired. The MDS documented R25 transferred and ambulated independently and required minimal assistance with transfers.

The "Behavior Care Plan," dated 05/30/23, documented the resident was aggressive during care. The care plan directed the staff to use a quiet approach when caring for the resident.

The "Antipsychotic Use Care Plan," dated 05/30/23, documented for staff to monitor for side effects which included nausea, vomiting, diarrhea, motor problems, blood sugar & cholesterol changes, increased mortality rate in

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 _____	07/11/2023

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 758	Continued From page 36 dementia, and tardive dystonia (abnormal condition characterized by involuntary repetitive movements of the muscles of the face, limbs and trunk). The "Physician Order" dated 02/28/23 directed the staff to administer Risperdal (antipsychotic)0.25 milligrams (mg) PO (by mouth) daily for aggression. R25's EMR lacked a documented physician rationale which included the multiple unsuccessful attempts for nonpharmacological symptom management and risk versus benefits for the continued use of an antipsychotic On 07/05/23 at 10:00AM, observation revealed R25 sat in a wheelchair near the nurse's room. On 07/11/23 at 08:30AM, Administrative Nurse D verified R25 received a routine antipsychotic medication for aggression. Administrative Nurse D verified the diagnosis for the use of the medication was not appropriate. Upon request the facility did not provide a policy for psychotropic medication use. The facility failed to ensure appropriate use for R25's Risperdal, placing the resident at risk for adverse side effects.	F 758		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		

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 _____	07/11/2023

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 761	Continued From page 37	F 761		

appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 15 residents. Based on observation, record review, and interview, the facility failed to assess and record the refrigerator temperatures in the medication room and failed to discard an expired medication in the same refrigerator. This placed the residents who received medications from the refrigerators at risk for receiving less potent or unintended effects from the medications.

Findings included:

- On 07/06/23 at 02:54 PM, observation in the medication room refrigerator revealed a one-half full box of bisacodyl (laxative)suppositories that

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 _____	07/11/2023

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 761	Continued From page 38	F 761		

expired 03/2023.

On 07/06/23 at 02:54 PM, Certified Medication Aide (CMA) S verified the above finding and stated she would discard the suppositories in the trash. CMA S stated night shift was responsible for checking outdates (expiration dates) in the medication room.

Review of the medication room refrigerator temperature logs revealed the following:
April 2023- lacked documentation on 13 days.
May 2023- lacked documentation on 14 days.
June 2023- lacked documentation on 14 days.
July 2023 from 1-6- lacked documentation on 4 days

On 07/06/23 at 02:55 PM, Licensed Nurse (LN) G stated the night shift was responsible for checking and recording the medication room refrigerator temperatures.

07/10/23 09:32 AM, Administrative Nurse D verified the lack of medication refrigerator temperatures and stated it was probably agency staff that did not check and record the refrigerator temperatures. Administrative Nurse D stated staff should check and record the medication room refrigerator temperatures daily.

Upon request the facility failed to provide a policy regarding expired medications and checking and recording medication room refrigerator temperatures.

The facility failed to asses and record the refrigerator temperatures in the medication room and failed to discard an expired medication stored in the refrigerator. This placed the residents who

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 _____	07/11/2023

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 761	Continued From page 39 received medications from the refrigerators at risk for receiving less potent or unintended effects from the medications.	F 761		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. Based on record review and interview, the facility administration failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for the 36 residents who reside in the facility which placed all residents at risk for decreased health and wellbeing. Findings included: - The facility failed to ensure staff provided cardiopulmonary resuscitation (CPR) to Resident (R) 41, who desired resuscitative measures indicated by his full code status (code status determination for residents who wish to receive CPR). On 04/08/23 at 05:00 PM, Licensed Nurse (LN) G observed R41 with irregular respirations. At 05:10 PM, LN G checked on R41 again and identified R41 had no pulse or respirations. Without considering R41's code status or initiating CPR, LN G placed a call to R41's representative, who did not answer. LN G then called Administrative Nurse E who informed LN G	F 835		

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 _____	07/11/2023

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 835	Continued From page 40	F 835		

that R41 was a "full code" and directed LN G to start CPR. At 05:22 PM, LN G activated 911 and then initiated CPR. The facility failed to ensure staff immediately initiated CPR upon identification of R41's cardiac arrest when staff delayed 12 minutes to place calls to resources other than 911. The delay placed R41 and all residents with a full code status in immediate jeopardy. The facility further failed to have a system in place to identify and ensure CPR certified staff were always present in the facility.

The facility failed to provide a sanitary environment to help prevent the development and transmission of communicable disease and infections when the facility failed to develop a water management plan to minimize the risk for development of Legionella (type of bacteria that can cause serious lung infections) or other waterborne pathogens (agents that cause disease or infection) from entering the facility water system.

The facility's Quality Assessment and Assurance (QAA) program failed to provide good faith efforts to identify multiple issues of concern. This placed the residents at risk for decreased quality of care and life.

On 07/10/23 at 01:49 PM, Administrative Nurse D stated the facility had no documentation regarding in-service training or re-education on CPR procedure and the facility did not provide CPR training for nurse aides or medication aides. Administrative Nurse D stated the facility did not have a list of staff certified in CPR.

On 07/11/23 at 10:35 AM, Administrative Staff A stated she was unsure, but thought the 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 _____	07/11/2023

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 835	Continued From page 41 had identified and worked on some things for improvement for the Quality Performance Improvement Program (QAPI). She stated the previous Director of Nursing was in charge of QAPI activity. Administrative Staff A stated she was unaware of any facility system or plan in place for water management to minimize the risk for developing Legionella. Administrative Staff A stated the city tested the city water. The facility administration failed to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for the 36 residents who reside in the facility which placed all residents at risk for decreased health and wellbeing.	F 835		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective	F 867		

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 _____	07/11/2023

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 867	Continued From page 42	F 867		

systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and

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 _____	07/11/2023

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 867	Continued From page 43	F 867		

(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and

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 _____	07/11/2023

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 867	Continued From page 44	F 867		

assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 15 residents. Based on record review and interview, the facility's Quality Assessment and Assurance (QAA) program failed to provide good faith efforts to identify multiple issues of concern. This placed the residents at risk for decreased quality of care and life.

Findings included:

- The facility failed to provide mail service on Saturdays. Refer to F576.

The facility failed to complete Care Area Assessment Summaries. Refer to F636.

The facility failed to develop a comprehensive care plan for accidents. Refer to F656.

The facility failed to review and revise care plan for safe transfers. Refer to F657.

The facility failed to provide cardiopulmonary

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 _____	07/11/2023

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 867	Continued From page 45	F 867		

resuscitation (CPR) in a timely manner, and failed to maintain a system to verify CPR certifications for licensed staff. Refer to F678.

The facility failed to provide safe transfers and accident prevention. Refer to F689.

The facility failed to ensure competent nursing staff. Refer to F726.

The facility failed to act on recommendation from the Registered Pharmacist. Refer to F756.

The facility failed to use an antipsychotic (medication used to treat severe mental health disorders) medication appropriately. Refer to F 758.

The facility failed to store and dispose of expired medications. Refer to F761.

The facility failed to have effective administration to address resident care. Refer to F835.

The facility failed to have a system in place to prevent legionella and other water borne pathogens. Refer to F880.

The facility failed to have a designated and certified Infection Preventionist. Refer to 882.

On 07/11/23 at 10:35 AM, Administrative Staff A stated she was unsure, but thought the facility had identified and worked on some things for improvement for the Quality Performance Improvement Program (QAPI). She stated the previous Director of Nursing was in charge of QAPI activity.

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 _____	07/11/2023

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 867	Continued From page 46 Upon request the facility did not provide a QAPI policy. The facility's QAA program failed to provide good faith efforts to identify multiple issues of concern. This placed the residents at risk for decreased quality of care and life.	F 867		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.	F 868		

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 _____	07/11/2023

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 868	Continued From page 47 §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents. The sample included 15 residents. Based on record review and interview, the facility lacked evidence the required committee members attended the Quality Assessment and Assurance (QAA) Committee quarterly meetings. This placed the residents who resided in the facility at risk for decreased quality of care. Findings included: - On 07/11/23 at 10:30AM, the facility's Quality Assurance Performance Improvement (QAPI) meeting attendance sheets lacked signatures of attendees/committee members on the sheets. The sheets had just a "Yes" or "No" placed by the typde name of members who allegedly attended the meetings. On 07/11/23 at 10:30AM, Administrative Staff A stated the facility used to sign in for meetings but they now documented "Yes" or "No" if member attended meeting on an electronic form. She confirmed the facility did not document proof or signatures. Upon request the facility did not provide a QAPI policy. The facility failed to retain evidence the required	F 868		

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 _____	07/11/2023

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 868	Continued From page 48 QAA and QAPI members attended meetings at least quarterly which placed residents at risk of decreased quality of care services.	F 868		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		

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 _____	07/11/2023

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 880	Continued From page 49	F 880		

reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 15 residents. Based on record review and interview the facility failed to provide a sanitary environment to help prevent the development and transmission of communicable disease and infections when the facility failed to

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 _____	07/11/2023

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 880	Continued From page 50 develop a water management plan to minimize the risk for development of Legionella (type of bacteria that can cause serious lung infections) or other waterborne pathogens (agents that cause disease or infection) from entering the facility water system. Findings included: - On 07/11/23 at 07:44 AM, when asked to see the facility's water management plan, Maintenance Staff (MS) U stated he had never heard of Legionella disease. On 07/11/23 at 10:11 AM, Administrative Staff A stated she was unaware of any facility system or plan in place for water management to minimize the risk for developing Legionella. Administrative Staff A stated the city tested the city water. Upon request the facility failed to provide a policy regarding Legionella. The facility failed to develop a water management plan for detecting Legionella and other waterborne pathogens in the water system. This placed the 36 residents at risk for developing an infection.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training	F 882		

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 _____	07/11/2023

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 882	Continued From page 51	F 882		

in nursing, medical technology, microbiology, epidemiology, or other related field;

§483.80(b)(2) Be qualified by education, training, experience or certification;

§483.80(b)(3) Work at least part-time at the facility; and

§483.80(b)(4) Have completed specialized training in infection prevention and control.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents. The sample included 15 residents. Based on interview and record review the facility failed to provide an designated and certified Infection Preventionist (IP) to manage and monitor the facility's Infection Prevention and Control Program (IPCP) for the 36 residents who resided in the facility. This placed the residents at risk for infections and health problems.

Findings included:

- On 07/05/23 at 12:30 PM, Administrative Staff A stated the facility had no certified IP to provide oversight and monitor the facility's IPCP in the facility. Administrative Staff A stated she was enrolled in the IP program but had not completed it.

Upon request the facility failed to provide a policy regarding IP.

The facility failed to provide an IP who held the required certification to manage and monitor the facility's Infection Prevention and Control Program for the 36 residents who resided in 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 _____	07/11/2023

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 882	Continued From page 52 facility. This placed the residents at risk for infections and health problems.	F 882		