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	175422	A. BUILDING _____ B. WING _____	C 07/31/2023

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 complaint investigations #KS00181786 and #KS00181689. The 2567 was sent electronically on 08/14/23	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: The facility identified a census of 37 residents. Two residents were reviewed for roommate/room change notification. Based on observations, record review, and interviews, the facility failed to provide written notification, including the reason for the change, to Resident (R) 1 and/or her representative before R2 became her roommate. This deficient practice had the risk for miscommunication between R1/her representative and the facility and placed R1 at risk for decreased psychosocial well-being related to getting a new roommate.	F 559		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/14/2023

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

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Findings included:

- The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance and repeated falls.

The "Annual Minimum Data Set (MDS)' dated 04/30/23, documented R1 had Brief Interview for Mental Status (BIMS) score of seven which indicated severe cognitive impairment. R1 was independent with setup help for bed mobility and eating; required limited assistance with one staff for transfers, walking, locomotion, dressing, toileting, and personal hygiene. R1 had one non-injury fall since last assessment.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 05/05/23, lacked an analysis of findings.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 05/05/23, lacked an analysis of findings.

The "Care Plan," last revised 04/21/22, documented R1 had an ADL self-care performance deficit related to weakness and balance deficits and directed R1 chose to transfer independently at times but was encouraged to call for assistance.

The "Care Plan," last revised 04/21/22, documented R1 had impaired cognitive function/dementia or impaired thought processes. The "Care Plan" documented an intervention, last revised on 05/09/22, that directed staff used R1's preferred name, identified themselves at each

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interaction, faced R1 when speaking to her and made eye contact, reduced any distractions, and provided R1 with necessary cues and allowed her time to express her thoughts.

R1's medical record lacked evidence that she and/or her representative were notified verbally or in written form that she was to receive a roommate.

R2's EMR revealed a "Communication with Family" note on 07/19/23 at 02:42 PM that documented R2's representative gave permission to move to another room. The note recorded staff gave R2's representative the new room number, and that he was to be notified when R2 moved.

R2's EMR revealed a "Health Status Note" on 07/20/23 at 01:35 PM that R2 and her belongings moved to R1's room and a message was left for her representative that she had been moved.

On 07/31/23 at 02:00 PM, R1 laid in bed and asked the staff in the hallway where her husband was. She used the left bed rail with her left arm to move from a lying to a sitting position in bed.

On 07/31/23 at 02:06 PM, Social Services X stated when a resident was to move rooms or to get a roommate, she contacted the family to let them know along with the resident. She stated the notification was documented in the progress notes. Social Services X stated R1and her family were not notified that she was to get a roommate.

On 07/31/23 at 03:01 PM, Maintenance U stated the day R1 was to get a roommate, he moved a bed into the room and R1 asked if there were ants in the bed to run the roommate away. He

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F 559	Continued From page 3 stated R1 asked if there was anything she could throw at her and decided she would just sing to get the roommate out. Maintenance U stated R1 did not seem happy about getting a roommate and stated he reported her comments to a Certified Medication Aide (CMA). On 07/31/23 at 04:04 PM, Administrative Nurse D stated Social Services X did the family notifications to let them know about a new roommate and to see if it was okay. She stated it was reported to her from Maintenance U that R1 was plotting on how to get rid of R2. The facility's "Transfers Within the Facility" policy, not dated, directed transfers within the facility were made with the consultation of the resident and/or surrogate decision-maker. The resident and family were consulted and the reasons for the move were explained, and the resident or responsible party were notified prior to transfer. The "policy" directed if the resident was being transferred to a shared bedroom, any resident currently residing in that room was notified and the notification was documented in each resident's clinical record. The facility failed to provide written notification, including the reason for the change, to R1 and/or her representative before R2 became her roommate. This deficient practice had the risk for miscommunication between R1/her representative and the facility and placed R1 at risk for decreased psychosocial well-being related to getting a new roommate.	F 559		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		

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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 37 residents. The sample included four residents with two residents reviewed for abuse. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility staff failed to report bruises of unknown origin as potential abuse or neglect to the State Agency

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(SA), within the mandated time frame. This deficient practice placed the resident at risk for unresolved and ongoing abuse, a decrease in psychosocial well-being, and further injuries.

Findings included:

- The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance and repeated falls.

The "Annual Minimum Data Set (MDS)' dated 04/30/23, documented R1 had Brief Interview for Mental Status (BIMS) score of seven which indicated severe cognitive impairment. R1 was independent with setup help for bed mobility and eating; required limited assistance with one staff for transfers, walking, locomotion, dressing, toileting, and personal hygiene. R1 had one non-injury fall since last assessment.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 05/05/23, lacked an analysis of findings.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 05/05/23, lacked an analysis of findings.

The "Care Plan," last revised 04/21/22, documented R1 had an ADL self-care performance deficit related to weakness and balance deficits and directed R1 chose to transfer independently at times but was encouraged to call for assistance.

The facility's "Investigation" dated 07/26/23,

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documented on 07/22/23, R1 was found to have two small blue/yellow spots on her left upper extremity (LUE). R1 complained of increasing pain so the nurse had R1 transferred to the Emergency Room (ER) for further evaluation. The ER found no acute fracture with a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) noted in the ER report. Upon examination throughout the weekend, R1's LUE appeared to become increasingly swollen, red, tender, and warm to touch. She was sent to the walk-in clinic on 07/24/23 for further evaluation and was started on antibiotics. Licensed Nurse (LN) G interviewed R1 at the time of the noticed injury about abuse/neglect potential, R1 had memory/cognitive deficits but did not recall an injury or abuse. Administrative Nurse D interviewed evening staff from 07/21/23 to determine when the injury occurred and any evidence of abuse; there were no obvious signs of abuse, and no injury was noted by staff.

The "Notes" tab of R1's EMR revealed the following:

A "Health Status Note" on 07/22/23 at 08:15 AM documented at 06:00 AM, LN G observed R1 turning over on her left side in bed, adjusting the air conditioner in the room. At 07:30 AM, R1 complained about her left upper arm and showed LN G who noted on her upper left inner arm, a five centimeters (cm) by six cm light purple, yellow bruise and on her upper left lateral arm, a six cm by eight cm light purple bruise. R1 complained of not being able to lift arm and was asked not to move her left arm. The "Note" documented R1 denied falling and did not remember hurting her left arm. R1's family was

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notified and that she was to be transferred to the ER. Administrative Nurse D was notified.

A "Root Cause Analysis" note on 07/24/23 at 09:00 AM documented R1 was evaluated for reported LUE pain/bruising. Nursing staff reported over the weekend thar R1 had pain/bruising that started on 07/22/23 as a small yellowish area that progressively became larger in size and red. Staff reported R1 had no injuries, no falls, and no complaints on 07/21/23 evening when cares were provided. R1 got a new roommate on 07/20/23, however, the roommate was chair bound with severe cognitive deficit. There was no physical altercation noted or potentially possible given the roommate's level of function. Family and provider were informed of R1's condition and the incident report was called to the SA.

On 07/31/23 at 02:00 PM, R1 laid in bed and asked staff in the hallway where her husband was. She used the left bed rail with her left arm to change from a lying to sitting position in bed.

On 07/31/23 at 12:06 PM, Administrative Nurse D stated LN G called her on 07/22/23 that she planned to send R1 to the ER for lack of motion and two yellowish/blue spots on her left arm that might have been bruising. She stated the investigation process was started on 07/24/23 and she called the SA hotline to report the incident that day.

On 07/31/23 at 03:33 PM, Certified Nurse Aide (CNA) M stated if there was an injury of unknown origin, he contacted the nurse so she could assess it then he filled out a witness statement.

On 07/31/23 at 03:48 PM, LN G stated if there

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F 609	Continued From page 8 was an injury of unknown origin, the doctor, family, and Administrative Nurse D were notified. On 07/31/23 at 04:04 PM, Administrative Nurse D stated injuries of unknown origin were reported to the SA within two hours. Staff reported any injuries of unknown origin to the provider, family, and to her. She stated the nurse on duty did the initial investigation and she did the actual investigation for the SA when she came in. Administrative Nurse D was not sure who the abuse coordinator was for the facility but said it was probably Social Services X or herself. The facility's "Abuse, Neglect, and Exploitation Policy," not dated, directed initial reporting of allegations were reported by the Administrator or designee within two hours or within 24 hours to the SA. The "policy" directed if events that caused suspicion did not result in serious bodily injury, the facility reported to the SA within 24 hours. The facility failed to ensure R1 received the necessary protective oversight to prevent potential abuse and/or neglect when the facility staff failed to report bruises of unknown origin as potential abuse or neglect to the SA, within the mandated time frame. This deficient practice placed the resident at risk for unresolved and ongoing abuse, a decrease in psychosocial well-being, and further injuries.	F 609		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure	F 700		

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correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.

§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 37 residents. The sample included one resident reviewed for bed rail usage. Based on observation, record review, and interviews, the facility failed to assess Resident (R) 1 for safe usage of bed rails, failed to educate R1's Durable Power of Attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to)/representative on the risks versus benefits of using bed rails, and failed to obtain consent from the DPOA/representative to utilize bed rails on R1's bed. This deficient practice had the risk for accidents and/or hazards and miscommunication between the DPOA/representative and facility.

Findings included:

- The "Diagnoses" tab of R1's Electronic Medical

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Record (EMR) documented diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance and repeated falls.

The "Annual Minimum Data Set (MDS)' dated 04/30/23, documented R1 had Brief Interview for Mental Status (BIMS) score of seven which indicated severe cognitive impairment. R1 was independent with setup help for bed mobility and eating; required limited assistance with one staff for transfers, walking, locomotion, dressing, toileting, and personal hygiene. R1 had one non-injury fall since last assessment.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)" dated 05/05/23, lacked an analysis of findings.

The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential CAA" dated 05/05/23, lacked an analysis of findings.

The "Care Plan," last revised 04/21/22, documented R1 had an ADL self-care performance deficit related to weakness and balance deficits and directed R1 chose to transfer independently at times but was encouraged to call for assistance.

The "Care Plan," dated 07/25/23, documented R1 had a potential/actual impairment to skin integrity of the left upper arm and directed staff padded bed rails, wheelchair, or any other source of potential injury if possible.

R1's medical record lacked evidence of a bed rail assessment, bed rail education, and/or bed rail consent.

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On 07/31/23 at 02:00 PM, R1 laid in bed and asked staff in the hallway where her husband was. She used the left bed rail with her left arm to move from a lying to sitting position in bed.

On 07/31/23 at 03:48 PM, Licensed Nurse G stated if a resident requested to have bed rails put on, the facility put bed rails on, but she had not seen an assessment or consent form that was used before putting bed rails on the bed.

On 07/31/23 at 04:04 PM, Administrative Nurse D stated the facility was not able to use full or half rails but quarter rails were used at nursing's discretion to her knowledge. She stated she found a bed rail policy with a consent form that was not being used but she would be implementing it from that point on.

The facility's "Bed Rails" policy, not dated, directed the facility ensured correct installation, use and maintenance of bed rails including but not limited to: the facility assessed the resident for risk of entrapment from bed rails prior to installation; the facility reviewed the risks and benefits of bed rails with resident/representative and obtained informed consent prior to installation; the facility ensured the bed's dimensions were appropriate for the resident's size and weight; and the facility followed the manufacturer's recommendations and specifications for installing and maintaining bed rails.

The facility failed to assess R1 for safe usage of bed rails, failed to educate R1's DPOA/representative on the risks versus benefits of using bed rails, and failed to obtain consent

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F 700	Continued From page 12 from the DPOA/representative to utilize bed rails on R1's bed. This deficient practice had the risk for accidents and/or hazards and miscommunication between the DPOA/representative and facility.	F 700		