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	175422	A. BUILDING _____ B. WING _____	C 12/16/2024

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 are the result of abbreviated survey and complaint investigation KS00192346. The 2567 was sent electronically on 12/30/24.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/30/2024

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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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 38 residents with three residents reviewed for resident's rights. Based on record review, observation, and interview, the facility failed to promote Resident (R) 1's right to choose, failed to respect R1's wishes, and failed to treat R1 with dignity and respect. On 12/05/24 at approximately 09:30 PM, R1 sat in his room in his wheelchair. Certified Nurse Aide (CNA) O heard another CNA say R1 did not want to go to bed. CNA M and CNA N went into R1's room and made R1 go to bed despite his protest. R1 became resistant to the transfer from his wheelchair to the bed and started hitting and kicking out at CNA M and CNA N. R1 yelled, "No, no, no, no," and "Get out of here." CNA O entered R1's room and observed R1 lying on his bed with his arms and legs up in a defensive position. CNA O told CNA M and CNA N they could not force R1 to go to bed. This deficient practice created psychosocial impairment and placed him at risk for injury, impaired dignity, and decreased quality of life.

Findings included:

- The Electronic Medical Record (EMR) documented R1 had diagnoses of age-related

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cognitive decline, anxiety, hypertension (high blood pressure), a need for assistance for personal care, and chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing).

The "Quarterly Minimum Data Set (MDS)," dated 11/12/24, documented R1 had a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R1 required partial to substantial assistance for all his activities of daily living (ADLs) except eating, which R1 only required set-up assistance. R1's MDS documented no behaviors or resistance to care occurred.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 05/17/24, documented R1 as alert and able to make his needs known. R1 had confusion and required cues for all cares.

The "Functional Abilities CAA," dated 05/17/24, documented R1 as toe-touch weight-bearing and required assistance from two staff for all ADLs.

R1's "Care Plan" directed staff R1 required one to two staff assistance with ambulation for short distances and R1 required the assistance of one staff for bathing, bed mobility, dressing, toilet use, and transfers (08/15/24). The care plan documented R1 had impaired cognitive status and directed staff to cue, re-orient, and supervise R1 as needed (05/16/24). The care plan directed staff to know R1 required the use of oxygen at three liters (L) per nasal cannula to keep his oxygen saturation (percentage of oxygen in the blood) above 90%; R1 became short of air with

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exertion and when lying down (08/15/24).

The "Behavior Note," dated 12/05/24, documented Licensed Nurse (LN) G was notified by CNA M and CNA N that R1 had removed his nasal cannula. The CNAs reported during their time assisting R1 to bed, R1 experienced confusion and was combative grabbing at their arms. LN G entered R1's room and CNA O was consoling R1. R1's nasal cannula was intact. R1 sat at the edge of the bed with arms to each side grasping the edge of the bed. R1 was short of breath and his oxygen saturation was 90%. LN G checked the nebulizer treatment to see if all the medication had been used. While LN G placed the mask back to the nebulizer machine, R1 attempted to tell LN G how to put it; he became short of air and agitated but was quick to be redirected to focus on his breathing. LN G left CNA O to continue to console R1.

CNA M's undated "Witness Statement," documented CNA M was called into R1's room by CNA N around 09:00 PM to help ambulate R1 to bed. R1 had been in his wheelchair with no oxygen for an extended period of time. R1 stated he was ready to go to bed. CNA M and CNA N placed R1's walker in front of his wheelchair and told R1 he needed to stand up to go to bed. R1 responded, "I know that." CNA M and CNA N then proceeded to assist R1 in standing and once R1 was up, he became increasingly agitated, screaming, pushing backward, flailing around, and stating he did not want to go to bed. CNA M recorded the staff's main concern was to stop R1 from falling. R1 had a gait belt on and started to flail and become unsafe and the wheelchair was already moved from R1 pushing backward, so CNA M and CNA N helped R1 to the side of the

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bed where R1 threw himself back and started kicking and punching. CNA M and CNA N tried to deflect R1's hands so they could get R1's oxygen tubing from around his and back into his nose and remove the gait belt. After that, the staff determined R1 was safe, so they did not do perineal care or finish the nightly routine due to severe agitation. CNA O entered R1's room and asked what was going on. R1 said, "I want these broads to leave the room." CNA M and CNA N exited the room to notify LN G of the issue. CNA O stayed behind. LN G had CNA M check R1's oxygen saturation about 20 minutes later and it was back to 90%. At 09:45 PM CNA M took R1's foot pedals back to his room and set the pedals in R1's doorway; R1 was calmed down and friendly and wanted his door cracked halfway open. R1 was back to his baseline and sat in his recliner.

CNA N's undated "Witness Statement," was identical to CNA M's "Witness Statement."

CNA O's "Witness Statement," dated 12/06/24, documented another CNA told CNA O that R1 did not want to go to bed. CNA M and CNA N went into R1's room to put R1 to bed. CNA O stated she had gone into the bathroom when she heard R1 yell, "No, no, no." CNA O also heard R1's chair alarm go off. CNA O went to R1's door and stood outside the door listening. CNA O heard CNA N say, "You're going to die, you need to put your oxygen on." CNA O heard R1's chair alarm go off a second time and R1 yelled, "Get out of here!" CNA O then entered R1's room and told CNA M and CNA N they could not force R1 to go to bed if he refused. CNA M and CNA N stated they were just trying to put on R1's oxygen. CNA O stated she saw R1 on his bed with his arms and legs up in a defensive manner. CNA O told

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CNA M and CNA N to just go and that she would take care of R1.

The "Health Status Note," dated 12/06/24, documented LN H was in doing rounds at 06:30 AM and noticed R1's right hand was bruised from his knuckles up to his wrist, which measured 9 centimeters (cm) by 7 cm and two bruises on R1's left hand, which measured 5 cm by 4 cm and 3 cm by 4 cm. R1 was unsure how the bruises happened, but stated they did not hurt. R1 was on 325 milligrams (mg) of aspirin daily.

The "Health Status Note," dated 12/07/24 at 11:01 AM, documented a follow-up on R1's bruising. R1 continued to have bruising on his right hand and left arm and started to have bruising on his right and left upper arms and left chest. R1 stated he did not remember anything that happened, and he was not hurt. R1 was alert and oriented to person and place. R1's wife was present during the skin assessment.

The "Health Status Note," dated 12/07/24 at 11:13 PM, documented a follow-up on R1's bruising to the right hand, left arm, bilateral upper arms, and left chest. R1 did not remember how the bruising occurred. R1 was alert and oriented to person and place.

The "Health Status Note," dated 12/08/24, documented R1 continued to be monitored for bruising. No new bruising was noted, but R1 continued to have bruises on the right hand, left hand, lower forearm, upper arm, and a few little bruises on the left chest. R1 continued to deny pain.

The "Health Status Note," dated 12/09/24,

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documented the assessment showed no further bruising to R1's body. R1 denied pain at the time of assessment.

The "Facility Incident Report," dated 12/12/24, documented at approximately 04:23 PM on 12/06/24, Administrative Nurse D received a report from CNA O of a possible abuse, neglect, and exploitation (ANE) situation regarding R1. CNA O's allegation stated R1 may have been put to bed by CNA M and CNA N after R1 stated he did not want to go to bed. Staff noted bruising on R1's right wrist/hand on 12/06/24. CNA M and CNA N were suspended immediately and placed on the "Do Not Return" list to prevent them from picking up any further shifts during the investigation. CNA O was also immediately suspended. R1 was not able to verbalize if the allegation was true. R1 did not know what happened to cause the bruising and denied pain. The facility notified the police. The investigation included staff training on abuse and neglect on 12/06/24 but did not include education on residents' rights.

On 12/16/24 at 09:30 AM, R1 sat in his recliner with his legs elevated. R1 visited with his wife. R1 had light pink to light red bruises that were fading on his right hand and left wrist. R1 stated he did not remember getting the bruises but thought he must have fallen. R1 stated he was not afraid to live in the facility and asked where that idea would come from.

On 12/16/24 at 09:30 AM, R1's representative stated she came to visit R1 on 12/06/24 at 09:00 AM and saw all of the bruising and was very concerned about what had happened because she had been with R1 all day on 12/05/24 from

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09:00 AM to 2:00 PM and he had no bruises. R1's representative stated she was told two CNAs had forced R1 to go to bed at around 09:30 PM and that was how the bruises happened. R1's representative stated R1 does not like to go to bed early and would not go to bed until after the news or sometimes not at all and would stay in his recliner. She stated R1 could not breathe well lying down.

On 12/16/24 at 10:00 AM, CNA O stated she did not see anything that happened but heard R1 from the staff bathroom yelling, "No, no, no, no." CNA O stated she was concerned and went to R1's door and then heard the chair alarm sound so she thought, "Oh they are in there." CNA O stated the chair alarm was silent but then turned back on as if CNA M and CNA N had sat R1 down but then stood him right back up. CNA O stated she heard R1 yell, "Get out of here!" CNA O entered the room and saw R1 lying on the bed with his arms and legs up in a defensive position with CNA M and CNA N standing at the bedside. CNA O stated she told CNA M and CNA N they could not force R1 to go to bed if he did not want to. CNA O stated CNA M and CNA N left the room and CNA O stayed to console R1. R1 was breathing hard and was visibly upset. CNA O stated R1 had never been combative or resistant to care but would tell staff when he did not want to do something, and they would listen to him and let him be. CNA O stated she did not report the allegation until the next day when she came to work.

On 12/16/24 at 10:30 AM, CNA P stated R1 had never been violent with care but would say he did not want to do something and sometimes was easily re-directable and other times was not.

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On 12/16/24 at 11:00 AM, LN I stated R1 could be resistant to care and stubborn, but she had never experienced him hitting, kicking, or pinching. LN H stated R1 had been taking aspirin 325 mg daily and bruised easily. LN I stated that R1's aspirin had been discontinued.

On 12/16/24 at 11:30 AM, Administrative Nurse D stated she did not think CNA M and CNA N had forced R1 to go to bed. Administrative Nurse D stated she thought R1's oxygen was off and since no one knew how long it had been off R1 was confused. Administrative Nurse D stated all nursing staff were educated covering ANE on 12/06/24 and CNA M and CNA N refused to come in for the education because, in their words, Administrative Nurse D was taking the whole incident out of context. Administrative Nurse D stated the facility canceled all shifts with the CNAs' agency because they were so hard to deal with throughout the incident.

The facility's undated "Resident Rights Policy," documented that each resident in this facility has the right and will be afforded the right to a dignified existence, self-determination, and communication with access to persons and services inside and outside the facility without interference, coercion, discrimination, or reprisal. No staff member or contracted provider of care will hamper, compel, treat differently, or retaliate against a resident for exercising Resident Rights. It is the responsibility of all who work in this facility including employees of the facility and any others who provide services to the residents of the facility to advocate and protect the rights of each resident. All staff members are trained on the Resident Rights Policy at the time of employment,

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prior to providing care to residents, and at least annually to ensure understanding and competency related to ensuring each resident's Resident Rights.

The facility failed to promote R1's right to choose, failed to respect R1's wishes, and failed to treat R1 with dignity and respect. This deficient practice created psychosocial impairment and placed him at risk for injury, impaired dignity, and decreased quality of life.

The severity was determined to be actual harm based on the "reasonable person" concept due to the circumstances of R1's cognitive impairment and inability to self-identify and express his feelings.