STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent out electronically on 02/25/25.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or	F 580		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 580	Continued From page 1	F 580		

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to notify the physician of episodes of syncope (fainting or passing out) and lightheadedness of one resident, Resident (R) 32. This placed the resident at risk for further decline and a delay in treatment.

Findings included:

- The "Electronic Medical Record" (EMR) documented R32 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 580	Continued From page 2	F 580		

type two, and arteriosclerotic heart disease (buildup of plaque in the arteries [blood vessels that carry blood away from the heart]).

The "Significant Change Minimum Data Set" (MDS), dated 04/03/24, documented R32 had intact cognition. R32 was dependent upon staff for transfers and toileting. R32 required substantial assistance with dressing and did not ambulate. The MDS documented R32 was frequently incontinent of bladder and bowel and had lower functional impairment on one side.

The "Quarterly MDS," dated 01/01/25, documented R32 had moderately impaired cognition. R32 was dependent upon staff for dressing, transfers, mobility, and toileting. The MDS documented R32 was frequently incontinent of bladder and bowel and had lower functional impairment on one side.

The "Care Plan" dated 01/14/25, initiated on 06/14/23, directed staff to use a sit-to-stand lift for all transfers. The update, dated 06/17/24, directed staff to use a full mechanical lift (a medical device used to assist individuals with mobility limitations in transferring between surfaces) and two staff members. The care plan lacked direction to staff if the resident should become lightheaded or have a syncope episode during transfers.

The "Nurse's Note" dated 06/07/24 at 05:50 PM, documented, R32 was sat up in the sit-to-stand lift and because lightheaded. Staff sat R32 down and R32 stated that she felt strange, Staff encouraged R32 to drink more water and rest. The EMR lacked documentation the physician was notified of the episode.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 580	Continued From page 3	F 580		

The "Nurse's Note" dated 06/17/24, documented during a transfer with the sit-to-stand lift, R32's eyes rolled into the back of her head, and she stated, "Put me down." R32 was lowered back into her wheelchair and R32 stated, "I just saw stars." The note stated the assistant director of Nursing (ADON) would talk with R32 regarding the use of a full lift mechanical lift. The EMR lacked documentation the physician was notified of the episode.

The "Nurse's Note" dated 06/18/24 at 08:00 PM, documented R32 was unhappy with the use of the full mechanical lift. R32 stated she had multiple syncope episodes with the sit-to-stand lift. R32 stated she was being hooked up to the lift too long or she was being stood too high. The note documented staff explained to R32 that staff barely had her stood up when she would have the episodes and that it was not safe to use the sit-to-stand lift.

On 02/12/25 at 12:46 PM, CNA M and CNA N attached the sling to the full lift raised R32 from the bed, and transferred her to the recliner. R32 did not appear to be afraid or had any health issues while up in the sling and thanked the CNAs after she was lowered into the recliner.

On 02/12/25 at 01:00 PM, CNA M stated there had not been any more episodes of passing out since they changed from a toileting sling to a regular sling.

On 02/13/25 at 08:45 AM, Licensed Nurse (LN) H stated she was unsure why R32 kept getting lightheaded or passing out. LN H verified she could not find any information that the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 580	Continued From page 4 had been notified of the episodes. LN H verified there was no direction for staff in the care plan should R32 have any more episodes of lightheadedness or syncopal episodes. On 02/13/25 at 12:55 PM, LN G stated the physician should have been notified when R32 had the syncopal episodes so that he would be aware and could find out why it kept happening. On 02/13/25 at 01:45 PM, Administrative Nurse G stated she was unaware of the syncope episodes R32 kept having. Administrative Nurse D stated that if she had been aware, she would have provided interventions in the care plan for staff. Administrative Nurse D further stated she expected staff to notify the physician for direction or treatment for R32. The facility's "Guidelines for Notifying Physicians of Clinical Problems" undated policy documented the physician would be notified whenever there was a significant change in the resident's condition. The physician would be notified to see if there would be a need to alter any treatments significantly. The LN had the responsibility of contacting a physician any time they believed a resident had developed a clinical problem, which required physician intervention. The LN, prior to contacting the physician, must have performed an assessment of the resident to provide to the physician. The facility failed to notify R32's physician of episodes of syncope and lightheadedness. This placed the resident at risk for further decline and a delay in treatment.	F 580		
F 657 SS=D	Care Plan Timing and Revision	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 5 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: The facility had a census of 50 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to revise a care plan with direction to staff for interventions when one resident has periods of syncope and lightheadedness, Resident (R) 32. This placed the resident at risk for decline.	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 6	F 657		

Findings included:

- The Electronic Medical Record (EMR) documented R32 had diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) type two, and arteriosclerotic heart disease (buildup of plaque in the arteries [blood vessels that carry blood away from the heart]).

The "Significant Change Minimum Data Set" (MDS), dated 04/03/24, documented R32 had intact cognition. R32 was dependent upon staff for transfers and toileting. R32 required substantial assistance with dressing and did not ambulate. The MDS documented R32 was frequently incontinent of bladder and bowel and had lower functional impairment on one side.

The "Quarterly MDS," dated 01/01/25, documented R32 had moderately impaired cognition. R32 was dependent upon staff for dressing, transfers, mobility, and toileting. The MDS documented R32 was frequently incontinent of bladder and bowel and had lower functional impairment on one side.

R32 "Care Plan" dated 01/14/25, initiated on 06/14/23, directed staff to use a sit-to-stand lift for all transfers. The update, dated 06/17/24, directed staff to use a full mechanical lift (a medical device used to assist individuals with mobility limitations in transferring between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 7	F 657		

surfaces) and two staff members. The care plan lacked direction to staff if the resident should become lightheaded or have a syncope episode during transfers.

The "Nurse's Note" dated 06/07/24 at 05:50 PM, documented, R32 was sat up in the sit-to-stand lift and because lightheaded. Staff sat R32 down and R32 stated that she felt strange, Staff encouraged R32 to drink more water and rest. The EMR lacked documentation the physician was notified of the episode.

The "Nurse's Note" dated 06/17/24, documented during a transfer with the sit-to-stand lift, R32's eyes rolled into the back of her head, and she stated, "Put me down." R32 was lowered back into her wheelchair and R32 stated, "I just saw stars." The note stated the Assistant Director of Nursing (ADON) would talk with R32 regarding the use of a full lift mechanical lift. The EMR lacked documentation the physician was notified of the episode.

The "Nurse's Note" dated 06/18/24 at 08:00 PM, documented R32 was unhappy with the use of the full mechanical lift. R32 stated she had multiple syncope episodes with the sit-to-stand lift. R32 stated she was being hooked up to the lift too long or she was being stood too high. The note documented staff explained to R32 that staff barely had her stood up when she would have the episodes and that it was not safe to use the sit-to-stand lift.

On 02/12/25 at 12:46 PM, CNA M and CNA N attached the sling to the full lift raised R32 from the bed, and transferred her to the recliner. R32 did not appear to be afraid or had any health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 8	F 657		

issues while up in the sling and thanked the CNAs after she was lowered into the recliner.

On 02/12/25 at 01:00 PM, CNA M stated there had not been any more episodes of passing out since they changed from a toileting sling to a regular sling.

On 02/13/25 at 08:45 AM, Licensed Nurse (LN) H stated she was unsure why R32 kept getting lightheaded or passing out. LN H verified she could not find any information that the physician had been notified of the episodes. LN H verified there was no direction for staff in the care plan should R32 have any more episodes of lightheadedness or syncopal episodes.

On 02/13/25 at 12:55 PM, LN G stated the physician should have been notified when R32 had the syncopal episodes so that he would be aware and could find out why it kept happening.

On 02/13/25 at 01:45 PM, Administrative Nurse D stated she was unaware of the syncope episodes R32 kept having. Administrative Nurse D stated that if she had been aware, she would have provided interventions in the care plan for staff. Administrative Nurse D further stated she expected staff to notify the physician for direction or treatment for R32.

The facility's "Care Plan Revisions" dated 04/23, documented the care planning process including resident assessment, goal setting, and interventions. When changes in condition, medications, or approaches occur, the care plan will be updated immediately. The care plan green sheet would be added to the resident's care plan placing one copy in the communication book and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 9 one in the care plan book. The care plan would be revised when there was a change in the problems and goals. The green sheets would be reviewed with each MDS and added as indicated to the resident's long-term care plan. Problems that are no longer applicable would be archived for possible future review or retrieval. The facility failed to revise R32's care plan with direction to staff when R32 had periods of lightheadedness and syncope. This deficient practice placed the resident at risk for decline.	F 657		
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 50 residents. The sample included 13 residents, with eight reviewed for falls. Based on observation, record review, and interview, the facility failed to evaluate the effectiveness of fall interventions and change or modify the ineffective interventions at preventing falls for Resident (R) 16. This placed the resident at risk for further falls and injury. Findings included: - The Electronic Medical Record (EMR) for R16 documented diagnoses of dementia (a	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 10	F 689		

progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), arteriosclerotic heart disease (buildup of plaque in the arteries [blood vessels that carry blood away from the heart]), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues).

The "Quarterly Minimum Data Set" (MDS), dated 01/24/24, documented R16's moderately impaired cognition. R16 required supervision with transfers but was independent with eating, dressing, mobility, personal hygiene, mobility, and ambulation. The MDS documented R16's no functional impairment, two or more falls with injury, and daily use of a bed and chair alarm.

The "Quarterly MDS," dated 01/15/25, documented R16 had severely impaired cognition. R16 required supervision with personal hygiene, transfers, dressing, and ambulation, and was independent with mobility. The MDS documented R16 had no functional impairment, had two or more falls with injury, and used a bed and chair alarm daily.

The "Fall Risk Assessments," dated 01/22/24, 04/22/24, 07/11/24, 10/11/24, and 01/09/25, documented R16 was at risk for falls.

R16's "Care Plan" dated 01/28/25, initiated on 05/03/23, directed staff to provide gripper socks when barefoot in his room and ensure R16 laid on top of his blankets to decrease slipping. The update, dated 05/01/23, directed staff to remind R16 to ask for assistance with long-distance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 11	F 689		

mobility, keep personal frequently used items within reach, and provide proper, well-maintained footwear. The update, dated 05/22/23, directed staff to educate R16 to slow down and take his time. The update, dated 10/03/23, directed staff to place non-skid socks on after he returned from supper. The update, dated 01/02/24, directed staff to place silent pressure alarms on while in bed and chair. The update, dated 03/09/24, directed staff to educate R16 on making sure gripper socks were on properly before attempting to ambulate. The update, dated 04/29/24, directed staff to place a stop sign in view of the recliner to call for assistance. The update, dated 06/07/24, directed staff to educate R16 on calling and waiting for assistance. The update, dated 09/21/24, directed staff to educate R16 on the risk of falling when he ambulates independently and for staff to continue to provide verbal reminders. The update, dated 10/15/24, directed staff to offer R16 a drink after he toilets during the night. The update, dated 01/14/25, directed staff to review with R16 the importance of staff assistance with ambulation.

The "Risk Note" dated 03/14/24 at 10:40 AM, documented R16 had a fall on 03/09/24 at 11:00 AM. R16's feet slipped on the floor when he got out of bed, and he fell to his buttocks. R16 denied pain and was assisted to stand, R16 had one sock off and the other sock was worn upside down. R16 was educated to keep both gripper socks on and make sure the grippers were on the bottom of his feet. The note further documented R16 had another fall on 03/11/24 at 11:45 AM. R16 transferred to his recliner, failed back up far enough, and slid down to the floor. R16 sustained a superficial (occurring on the surface of the skin) abrasion (scrape) to the top of his left knee, had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 12	F 689		

his pants down, and had on socks.

The "Risk Note" dated 04/04/24 at 10:45 AM, documented R16 had a fall on 04/01/24 at 12:50 PM when he tried to get something from his refrigerator and lost his balance. R16 sustained a skin tear to his right elbow.

The "Risk Note" dated 05/02/24 at 03:49 AM, documented R16 had a fall on 04/29/24 at 03:53 AM. R16 attempted to take himself to the bathroom and did not use his call light. R16 stated he reached for the grab bar, missed, and fell. R16 sustained a 3.3 centimeter (cm) x 0.3 cm abrasion with dark purple discoloration to the outer left arm. R16 was reminded to use his walker and call for assistance.

The "Risk Note" dated 06/13/24 at 12;28 PM, documented R16 had a fall on 06/06/24 at 04:00 AM. R16 took himself to the bathroom, fell, on his left elbow, and then took himself back to his bed. The note documented staff responded within a minute of his pressure pad alarm being activated and observed R16 getting back into bed. R16 sustained a skin tear to his left inner elbow which measured 1 cm x 1 cm, a bruise to his right elbow which measured 1.5 cm x 0.5 cm, and another bruise to the outer right elbow that measures 2 cm x 1.5 cm. R16 was educated on the importance of using his call light or staff assistance.

The "Risk Note" dated 10/11/24 at 10:40 AM, documented R16 had two noninjury falls on 10/06/24. The first fall at 08:20 PM, R16 attempted to get blankets from the top shelf of his closet. When he grabbed the blankets, they fell on top of him which caused him to lose his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 13	F 689		

balance and fall. The second fall occurred at 09:00 PM when R16 wanted to move his wheelchair closer to his bed, lost his balance, and sat down on the floor. R16 was re-educated to call for assistance.

The "Risk Note" dated 10/18/24 at 11:5 AM, documented R16 had a fall on 10/15/24 at 06:10 AM. R16 fell after he tried to get a drink of water from his pitcher in the refrigerator, lost his balance, and fell, R16 denied hitting his head and had no injuries.

The "Risk Note" dated 01/16/25 at 12:32 PM, documented that R16 had a fall on 01/14/25 at 08:00 AM. R16 fell in his room when he attempted to ambulate independently. R16 attempted to get himself up from the floor as staff entered the room. R16 had redness to his left knee, with an abrasion below the knee. R16 was reminded to use his call light for staff assistance.

The "Risk Note" dated 02/06/25 at 12:40 PM, documented R16 had a fall on 02/05/25 at 06:30 AM. R16 got up from his bed to ambulate unassisted, his legs weakened, and he fell. Staff noticed his pressure pad alarm had not alerted staff, as it was in the recliner, and he had been in bed.

On 02/12/25 at 01:06 PM, Certified Nurse Aide (CNA) M placed a gait belt around R16's waist and with CNA N's assistance, R16 stood and transferred from his wheelchair into his recliner. R16 stated he was weak and could not understand why he was so tired after he was transferred.

On 02/12/25 at 1:15 PM, CNA M stated he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 14	F 689		

very impulsive and would not wait for any assistance from staff. She stated he has had a lot of falls and staff checked on him frequently to remind him to call. CNA M stated that they keep an alarm on his bed and chair, and they have placed nonskid strips in front of his recliner and bed to keep him from slipping if he stands up alone.

On 02/13/25 at 12:45 PM, Licensed Nurse (LN) G stated R16 was going to do whatever he wanted and would never call for assistance due to his dementia. R16 had silent alarms for his bed and chair and staff were to get him up right away in the morning or he would get up unassisted. LN G stated with R16s dementia he does not remember to call, and his family just wanted him kept injury-free.

On 02/13/25 at 01:37 PM, Administrative Nurse D stated R16 could tell staff what he was doing at the time of the fall but due to his cognitive impairment, he does not remember to call for assistance. Administrative Nurse D verified the interventions on the care plan had not been effective due to his cognitive impairment.

The facility's "Fall Prevention and Management Protocol," revised 04/29/24, documented each resident would be assessed for the risk factors for falls at the time of move-in, return from a health care facility, and after a fall in the facility. After a fall, the resident was assessed for injuries and given the care/treatment needed at the time. The physician would be notified of the fall and would make the clinical decision to transfer to the hospital or be monitored. The falls would be investigated using a root cause analysis and would implement corrective action. A green care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 15 plan sheet in the fall packet was completed with fall interventions to be implemented. All falls with interventions are reported, and reviewed in a weekly risk meeting. The care manager would document in resident progress notes and the falls are reviewed in quarterly Quality Assurance and Performance Improvement (QAPI) and safety meetings. The facility failed to evaluate the effectiveness of fall interventions and change or modify the interventions that were ineffective at preventing falls for R16. This deficient practice placed the resident at risk for further falls and injury.	F 689		
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,	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 16	F 756		

and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 50 residents. The sample included 13 residents, with five reviewed for unnecessary medication. Based on observation, interview, and record review, the facility's pharmacist consultant failed to request an approved indication for the use of Seroquel (an antipsychotic -class of medications used to treat psychosis and other mental-emotional conditions), and the required physician-written clinical rationale for the continued use of Seroquel for Resident (R) 18. This deficient practice placed R18 at risk of receiving unnecessary antipsychotic drugs.

Findings included:

- R18's Electronic Medical Record (EMR) documented a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) with late-onset.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 17	F 756		

The "Quarterly Minimum Data Set" (MDS), dated 12/04/24, documented a Brief Interview for Mental Status (BIMS) score of 99, short and long-term memory loss with severely impaired cognition. The MDS documented R18 was dependent on staff for all activities of daily living. R18 received antipsychotic medication without a gradual dose reduction (GDR) and the MDS stated the physician had documented a clinical rationale on 12/04/24.

R18's "Care Plan," dated 12/17/24, directed staff to obtain lab work, and vital signs as ordered by the physician, and request GDRs per regulations with physician review for possible dose reduction. The care plan directed staff to observe R18 for changes or decline in cognitive status, provide one-to-one observation when indicated, and a psychiatric evaluation as indicated.

The "Physician Order," dated 05/21/24, directed staff to administer Seroquel 25 milligrams (mg), by mouth, at bedtime for severe anxiety.

The "Pharmacist Reviews," dated 11/25/24, recommended a GDR for Seroquel. The physician declined to perform a GDR and failed to provide a written clinical rationale for the use of the antipsychotic for anxiety.

On 02/12/25 at 11:35 AM, Certified Medication Aide (CMA) S administered cyclobenzaprine (muscle relaxant) in pudding, at the dining table. R18 took the medication without problems.

On 02/13/25 at 10:15 AM, Administrative Nurse D verified that the consultant pharmacist had not continued to request a written thorough clinical rationale for the use of the antipsychotic for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 18 anxiety. The facility's "Consultant Pharmacist Services Provider Requirements" policy, dated October 2019, stated that the consultant pharmacist provided pharmaceutical services including a review of the medication administration record (MAR) to ensure proper documentation of medication orders and administration of medication. The consultant pharmacist would communicate to the physician and the director of nursing potential or actual problems detected and other findings related to medication therapy orders. The facility's pharmacist consultant failed to request an approved indication for the use of Seroquel, and the required physician-written clinical rationale for the continued use of Seroquel for R18. This deficient practice placed R18 at risk of receiving unnecessary antipsychotic drugs.	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---	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 19	F 758		

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

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

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

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

§483.45(e)(5) PRN orders for anti-psychotic 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 50 residents. The sample included 13 residents, with five reviewed for unnecessary medication. Based on observation, interview, and record review the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 20	F 758		

facility failed to obtain an approved indication for use for Seroquel (antipsychotic -class of medications used to treat psychosis and other mental emotional conditions), and the required physician-written clinical rationale for why any attempted dose reeducation would be likely to impair the resident's function or cause psychiatric instability for Resident (R) 18. This deficient practice placed R18 at risk of receiving unnecessary antipsychotic drugs.

Findings included:

- R18's Electronic Medical Record (EMR) documented a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) with late-onset.

The "Quarterly Minimum Data Set" (MDS), dated 12/04/24, documented a Brief Interview for Mental Status (BIMS) score of 99, short and long-term memory loss with severely impaired cognition. The MDS documented R18 was dependent on staff for all activities of daily living. R18 received antipsychotic medication without a gradual dose reduction (GDR) and the MDS stated the physician had documented a clinical rationale on 12/04/24.

The care plan, dated 12/17/24, directed staff to obtain lab work, and vital signs as ordered by the physician, and request GDRs per regulations with physician review for possible dose reduction. The care plan directed staff to observe R18 for changes or decline in cognitive status, provide one-to-one observation when indicated, and a psychiatric evaluation as indicated.

The "Physician Order," dated 05/21/24, directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 21 staff to administer Seroquel 25 milligrams (mg), by mouth, at bedtime for severe anxiety. The "Pharmacist Reviews," dated 11/25/24, recommended a GDR for Seroquel. The physician declined to perform a GDR and failed to provide a written clinical rationale for the use of the antipsychotic for anxiety. On 02/12/25 at 11:35 AM, Certified Medication Aide (CMA) S administered cyclobenzaprine (muscle relaxant) in pudding, at the dining table. R18 took the medication without problems. On 02/13/25 at 10:15 AM, Administrative Nurse D verified the physician had not written a thorough clinical rationale for the use of the antipsychotic for anxiety. The "Psychotropic Medication Use and Management" policy, dated October 2018, stated the facility would use and administer psychotropic medication appropriately working with the physician interdisciplinary team to ensure the appropriate use, evaluation, and monitoring. The drug dosage must be periodically reduced, with the goal of discontinuing it or replacing it with another less potent prescription. All antipsychotics would be tapered as a gradual dose reduction unless clinically contraindicated by the physician. The facility failed to obtain an approved indication for use for the antipsychotic drug Seroquel or the required physician-written clinical rationale, placing R18 at risk of receiving unnecessary antipsychotic drugs.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 760	Continued From page 22 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: The facility had a census of 50 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to administer the correct physician-ordered dose of Ativan (antianxiety drug - a class of medications that calm and relax people) at the scheduled time for Resident (R) 20, placing R20 at risk for adverse effects resulting from the incorrect dose. Findings included: - R20's Electronic Medical Record (EMR) documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The "Quarterly Minimum Data Set" (MDS), dated 01/29/25, documented a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. The MDS documented R20 required supervision to maximum staff assistance with activities of daily living and received antianxiety medication. R20's "Care Plan," dated 02/11/25, directed staff to observe for anxiety or restlessness, strange noises, getting up or down, delusions or hallucinations, resisting cares, being stiff with	F 760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 760	Continued From page 23	F 760		

cares or grabbing, obsession over items, or paranoia. R20's care plan directed staff to inform the nurse for documentation and notify hospice, and his physician as indicated.

The "Physician Order," dated 08/02/24, directed staff to administer Ativan 0.5mg, (1/2 tablet 0.25mg) two times per day (AM and 1 PM) for anxiety/ restlessness.

The "Physician Order," dated 11/07/24, directed staff to administer the following:
Ativan 0.5mg daily at HS (bedtime) for anxiety for anxiety disorder.
Ativan 0.5mg, (1/2 tablet 0.25mg) two times per day (AM and PM) for anxiety or restlessness.

The "Physician Order," dated 12/04/24, had the following:
Ativan 0.5mg, daily at bedtime for anxiety for anxiety disorder.
Ativan 0.5mg, (1/2 tablet 0.25mg) two times per day (AM and 4 PM) for anxiety or restlessness.
Ativan 0.5mg, under tongue every 4 hours as needed for anxiety or restlessness for 6 months.

The "Progress Note" dated 09/05/24 at 02:12 PM, documented a Certified Medication Aide (CMA) alerted this nurse that R20's noon dose of Ativan was not administered yesterday by error. R20 had not shown any increased anxiety or restlessness from the missed dose at that time.

The "Progress Note" dated 10/08/24 at 10:34 AM, documented a CMA alerted this nurse of finding a medication error from last night. R20 had Ativan 0.5mg at bedtime scheduled but received Ativan 0.25mg last night. R20 had some restlessness this morning without being able to redirect. R20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 760	Continued From page 24	F 760		

had been climbing out of chairs and trying to walk. Staff tried to redirect with a magazine, 1:1, and a busy box. R20 continued to be restless and "trying to leave for work." Staff attempted multiple times to redirect and the nurse instructed the CMA to give as needed (PRN) Ativan to help manage anxiety.

The "Progress Note" dated 11/05/24 at 09:20 AM documented R20 had not received the scheduled dose of Ativan on 11/03/2024 at 02:00 PM. Staff education was performed, and the time of administration was adjusted.

The "Progress Note" dated 12/16/24 at 08:25 AM, documented a CMA reported to this nurse that the narcotic book showed that R20 received Ativan 1 mg at bedtime instead of the scheduled Ativan 0.5mg at bedtime. Staff education on checking correct dosages prior to giving medications was provided.

The "Progress Note" dated 12/23/24 documented a CMA reported R20 received the incorrect dose of Ativan at bedtime on 12/21/24 and 12/22/24.

The "Progress Note" dated 02/05/25 at 06:15 AM, documented the evening CMA reported a medication error on 02/04/25 at 06:15 PM. R20 was scheduled to receive Ativan 0.5 mg tab in the AM and PM. The morning shift CMA recorded administration on the MAR (Medication Administration Record), but the narcotic box check indicated that Ativan was not given. This nurse and evening CMA rechecked the narcotic medication and record, confirming it was not administered.

On 02/12/25 at 11:02 AM, R20 sat in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 760	Continued From page 25 wheelchair at a dining table and ate lunch independently. After sneezing several times, he started fidgeting, rolling his wheelchair back and forth. On 02/13/25 at 10:35 AM, Administrative Nurse E stated one-to-one education had been provided to CMAs. On 02/04/25 administration removed the CMA from medication passes until her education was done. The facility also had the physician change the times for the scheduled Ativan. On 02/13/25 at AM, Administrative Nurse D verified that staff were to administer physician orders as scheduled. The facility's "Reporting a Medication Error" policy, dated 12/17/2015, stated all medication errors were to be reported to the Director of Nursing following the guidelines listed. The guidelines stated the person discovering the error would report to their supervisor and the supervisor would review information. Staff were to notify the physician and family. The error would be discussed at the weekly high-risk meeting. The facility failed to administer the correct physician-ordered dose of Ativan at the scheduled time for R20. This deficient practice placed R20 at risk for adverse effects resulting from the incorrect dose.	F 760		
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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 26	F 880		

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 §483.71 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 27	F 880		

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 50 residents. Based on observation, record review, and interview, the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as air-conditioning units in large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by legionella). This deficient practice placed the residents at risk of contracting infectious processes.

Findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175404	A. BUILDING _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUHLER SUNSHINE HOME	400 S BUHLER ROAD BUHLER, KS 67522

(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 28 - On 02/13/25 at 10:17 AM, Maintenance Staff U stated he was not aware of whom managed the waterborne pathogen prevention program that included the prevention of Legionella disease. On 02/13/25 at 10:43 AM, Administrative Staff A reported he was not aware of further monitoring programs for Legionella disease. Administrative Staff A stated the facility had not mapped the water system for possible dead-end water sources. Upon request, the facility failed to provide a waterborne pathogen policy. The facility failed to implement a water management program to test and manage waterborne pathogens. This deficient practice placed the residents who resident in the facility at risk of contracting Legionella pneumonia.	F 880		