STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in KS00193247, KS00193683, KS00194165, and KS00194231. The 2567 was sent electronically on 04/08/25.	F 000		
F 550 SS=F	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.	F 550		

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
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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F 550	Continued From page 1	F 550		

§483.10(b)(1) The facility must ensure that the 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 had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to maintain an environment that promoted the dignity of Resident (R) 34, who had blood sugar testing and insulin administration, and R9, who also had insulin administration in the facility's dining room with other residents, staff, and visitors.0 This deficient practice placed the residents at risk for an undignified experience and embarrassment.

Findings included:

- On 03/25/25 at 11:21 AM, Licensed Nurse (LN) I performed a finger stick to obtain a drop of blood for testing R4's blood sugar level. R34, seated across the same table, stated, "I'm glad that's not me, I don't like needles." LN I then retrieved an insulin pen and injected insulin (a hormone that lowers the level of glucose in the blood) subcutaneously (beneath the skin) into R4's right arm at the dining room table.

On 03/25/25 at 11:29 AM, LN I administered R9's insulin subcutaneously while seated in the dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 550	Continued From page 2 room. The table R9 sat at had two other residents and a visitor also seated at the same table at the time of the administration of insulin. 03/26/25 at 09:25 AM, LN I reported giving insulin in the dining room if the resident wanted. LN I stated R34 had joked about needles, and the other residents and visitors did not mind if insulin was administered in the dining room, but could give the insulin and check blood sugars in the residents' rooms. On 03/26/25 at 01:50 PM, Administrative Nurse D verified that the residents could receive insulin privately if the resident chose to. The facility's undated "Right to Dignity" policy documented the facility would promote care for elders in a manner and an environment that maintained and enhanced each elder's dignity and respect in full recognition of the elder's individuality. The facility failed to maintain an environment that promoted the dignity of R34 and R9, who had insulin administered in the dining room with other residents, staff, and visitors present. The deficient practice placed the residents at risk for an undignified experience and embarrassment.	F 550		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 600	Continued From page 3	F 600		

corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

§483.12(a) The facility must-

§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview and record review, the facility failed to keep Resident (R) 35 free from verbal abuse during transport in the facility bus. This deficient practice placed R35 at risk for fear or mental anguish.

Findings included:

- R35's electronic medical record included diagnoses for cerebral infarction (stroke) causing hemiplegia (refers to complete paralysis on one side of the body) affecting the left side, cerebral edema (swelling of the brain tissue), and muscle weakness.

The "Admission Minimum Data Set" (MDS), dated 11/11/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R35 was dependent on staff for mobility, dressing, and hygiene. He used a manual wheelchair, had one non-injury fall, and a history of falls before admission.

R35's "Care Plan," dated 11/04/24, directed staff to transfer R35 with two staff and a total

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 600	Continued From page 4	F 600		

mechanical lift, initiated 11/04/24. Provide a Broda chair (specialized wheelchair) due to his inability to safely sit in a regular wheelchair, initiated: 11/06/2024

The "Grievance Log" complaint of 11/04/25 documented on 11/04/24 a new resident (R35) complained of being treated horribly by the transportation aide on his way to this facility. He reported he was yelled at, and cursed at several times because he kept sliding out of his wheelchair. He reported he was told, "F***, I have stopped every five miles for you, and I am not going to keep stopping for this." R35 felt like he shouldn't be yelled at for something he could not help. He reported he slid completely out of his wheelchair and then she got really mad and started yelling. The resident also called his family and told them how he was treated. Resolution: The Transportation Aide was educated on Abuse/Neglect/Exploitation.

The Witness statement from the transportation Aide, dated 11/01/24, stated she strapped the resident (R35) in the van securely, but she had to stop several times to pull him back up in his wheelchair. He told her he was sliding himself down. The transportation aide wrote she did show some frustration with him and told herself she needed to calm down. At one point his bottom was completely off the wheelchair and she could not pull him up, so she lowered him to the floor. She called the nursing home who sent out two aides to assist her.

The "Admission Note" dated 11/04/24 at 05:21 PM documented a new male resident was transported via the facility van and wheelchair. R35 required a full lift. He leaned to his left and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 600	Continued From page 5	F 600		

had no use of his left arm. R35 denied pain.

The "Social Services Note" dated 11/04/24 at 02:15 PM documented the SSD introduced herself to R35 in his room. He was lying in bed and asked her to adjust his blankets and turn up the heater because he was cold. The SSD assisted R35 with putting away his personal items. The note lacked documentation of any complaint of abuse.

The "Progress Note" dated 11/05/24 at 05:16 AM documented R35 did not sleep at all last night. Staff assisted him with repositioning about every 30 minutes during the night shift. R35 would throw the left side of his body out of bed. The nurse finally said to him "You have to be pushing yourself this way in order for you to be off the bed like this". R35 responded, "That's what they said in the hospital." The nurse educated him on ways to better keep himself from pushing himself out of bed and he did much better after the education.

The "Progress Note" dated 11/6/24 at 04:47 AM documented R35 continued to adjust well to the facility. R35 slid out of his wheelchair at shift change around 06:00 PM. R35 stated he slid out of his chair onto the floor and then laid down. He denied hitting his head. A complete assessment was completed along with risk management. R35 slept well all night and only rang this morning for pain medication due to left hip pain.

On 03/26/25 at 12:45 PM, R35 laid in bed, and a Broda chair with a three-inch pommel (raised area in the cushion to help prevent forward slipping) cushion was in his room. R35 was alert and oriented and reported he was verbally abused on the van ride to the facility when he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 600	Continued From page 6	F 600		

first admitted. James stated his wheelchair did not have the thing in the seat (pommel) that kept him from sliding. R35 reported the driver repeatedly got upset with him and cursed when he kept sliding forward during the ride. He reported no further problems when transported by the facility.

On 03/26/25 at 02:18 PM, Certified Nurse Aide (CNA) and Transportation Aide O, stated she took a regular wheelchair to transport R35 from the previous facility, he did not come with his own wheelchair. CNA O stated the previous facility did not give our facility any information that the resident was at risk of sliding forward. CNA O verified she was angry but had not cursed while transporting R35 in November 2024. Training for transporting residents was a class every two years with a state agency. She stated they have to demonstrate securing a resident during the class. She stated after the incident the administration educated her for ANE.

On 03/26/25 at 02:32 PM, Administrative Staff A verified the facility had not reported the allegation of verbal abuse to the state agency or investigated it that he knew of (he was not employed here in November). He stated the only documentation the facility could find was the grievance log and the transportation aide's note.

The facility's undated "Abuse, Neglect, and Exploitation" policy stated all residents of the facility would be free of physical, emotional, and sexual abuse, neglectful treatment, and misappropriation of funds and resources. The policy stated verbal abuse included willfully disparaging and derogatory terms to residents or their families or within their hearing. Residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 600	Continued From page 7 and their families could report a grievance orally or in writing and the Grievance Officer would immediately report the incident to the administrator of the facility. Any allegations of all types of staff-to-resident abuse would be reported to the facility administrator and to other official agencies including the State Agency. The policy stated witness statements would be obtained, an investigation performed, and a written report filed. The facility failed to keep R35 free from verbal abuse during transport in the facility bus. This deficient practice placed R35 at risk for fear or mental anguish.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 609	Continued From page 8	F 609		

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure staff reported an allegation of verbal abuse from Resident (R) 35 to the administrator immediately to investigate. This placed R35 at risk for ongoing abuse and or mistreatment.

Findings included:

- R35's electronic medical record included diagnoses for cerebral infarction (stroke) causing hemiplegia (refers to complete paralysis on one side of the body) affecting the left side, cerebral edema (swelling of the brain tissue), and muscle weakness.

The "Admission Minimum Data Set" (MDS), dated 11/11/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R35 was dependent on staff for mobility, dressing, and hygiene. He used a manual wheelchair, had one non-injury fall, and had a history of falls before admission.

R35's "Care Plan," dated 11/04/24, directed staff to transfer R35 with two staff and a total mechanical lift, initiated 11/04/24. Provide a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 609	Continued From page 9	F 609		

Broda chair (specialized wheelchair) due to his inability to safely sit in a regular wheelchair, initiated: 11/06/2024

The "Grievance Log" complaint of 11/04/25 documented on 11/04/24 a new resident (R35) complained of being treated horribly by transportation aide on his way to this facility. He reported he was yelled at, and cursed at several times because he kept sliding out of his wheelchair. He reported he was told, "F***, I have stopped every five miles for you, and I am not going to keep stopping for this." R35 felt like he shouldn't be yelled at for something he could not help. He reported he slid completely out of his wheelchair and then she got really mad and started yelling. The resident also called his family and told them how he was treated. Resolution: The Transportation Aide was educated on Abuse/Neglect/Exploitation.

The "Witness Statement" from the transportation Aide, dated 11/01/24, stated she strapped the resident (R35) in the van securely, but she had to stop several times to pull him back up in his wheelchair. He told her he was sliding himself down. The transportation aide wrote she did show some frustration with him and told herself she needed to calm down. At one point his bottom was completely off the wheelchair and she could not pull him up, so she lowered him to the floor. She called the nursing home who sent out two aides to assist her.

The "Admission Note" dated 11/04/24 at 05:21 PM documented a new male resident was transported via the facility van and wheelchair. R35 required a full lift. He leaned to his left and had no use of his left arm. R35 denied pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 609	Continued From page 10	F 609		

The "Social Services Note" dated 11/04/24 at 02:15 PM documented the SSD introduced herself to R35 in his room. He was lying in bed and asked her to adjust his blankets and turn up the heater because he was cold. The SSD assisted R35 with putting away his personal items. The note lacked documentation of any complaint of abuse.

The "Progress Note" dated 11/05/24 at 05:16 AM documented R35 did not sleep at all last night. Staff assisted him with repositioning about every 30 minutes during the night shift. R35 would throw the left side of his body out of bed. The nurse finally said to him "You have to be pushing yourself this way in order for you to be off the bed like this". R35 responded, "That's what they said in the hospital." The nurse educated him on ways to better keep himself from pushing himself out of bed and he did much better after the education.

The "Progress Note" dated 11/6/24 at 04:47 AM documented R35 continued to adjust well to the facility. R35 slid out of his wheelchair at shift change around 06:00 PM. R35 stated he slid out of his chair onto the floor and then laid down. He denied hitting his head. A complete assessment was completed along with risk management. R35 slept well all night and only rang this morning for pain medication due to left hip pain.

On 03/26/25 at 12:45 PM, R35 was lying in bed and a Broda chair with a three-inch pommel (raised area in the cushion to help prevent forward slipping) cushion was in his room. R35 was alert and oriented and reported he was verbally abused on the van ride to the facility when he was first admitted. James stated his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 609	Continued From page 11	F 609		

wheelchair did not have the thing in the seat (pommel) that kept him from sliding. R35 reported the driver repeatedly got upset with him and cursed when he kept sliding forward during the ride. He reported no further problems when transported by the facility.

On 03/26/25 at 02:18 PM, Certified Nurse Aide (CNA) and Transportation Aide O, stated she took a regular wheelchair to transport the resident from the previous facility, he did not come with his own wheelchair. CNA O stated the previous facility did not give our facility any information that the resident was at risk of sliding forward. CNA O verified she was angry but did not curse while transporting R35 in November 2024. Training for transporting residents was a class every two years with a state agency. She stated they have to demonstrate securing a resident during the class. She stated after the 11/04/24 incident the administration educated her for ANE.

On 03/26/25 at 02:32 PM, Administrative Staff A verified the facility had not reported the allegation of verbal abuse to the state agency or investigated it that he knew of (he was not employed here in November). He stated the only documentation the facility could find was the Grievance Log and the transportation aide's note.

The facility's undated "Abuse, Neglect, and Exploitation" policy stated all residents of the facility would be free of physical, emotional, and sexual abuse, neglectful treatment, and misappropriation of funds and resources. The policy stated verbal abuse included willfully disparaging and derogatory terms to residents or their families or within their hearing. Residents and their families could report a grievance orally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 609	Continued From page 12 or in writing and the Grievance Officer would immediately report the incident to the administrator of the facility. Any allegations of all types of staff-to-resident abuse would be reported to the facility administrator and other official agencies including the State Agency. The policy stated witness statements would be obtained, an investigation performed, and a written report filed. The facility failed to report an allegation of verbal abuse from Resident (R) 35 to the administrator and the state agency. This placed R35 at risk for ongoing abuse and or mistreatment.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The sample included 13 residents. Based on	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 610	Continued From page 13	F 610		

observation, record review, and interview, the facility failed to thoroughly investigate the allegation of verbal abuse immediately. This placed Resident (R) 35 at risk for ongoing abuse and or mistreatment.

Findings included:

- R35's electronic medical record included diagnoses for cerebral infarction (stroke) causing hemiplegia (refers to complete paralysis on one side of the body) affecting the left side, cerebral edema (swelling of the brain tissue), and muscle weakness.

The "Admission Minimum Data Set" (MDS), dated 11/11/24, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R35 was dependent on staff for mobility, dressing, and hygiene. He used a manual wheelchair, had one non-injury fall, and had a history of falls before admission.

R35's "Care Plan," dated 11/04/24, directed staff to transfer R35 with two staff and a total mechanical lift, initiated 11/04/24. Provide a Broda chair (specialized wheelchair) due to his inability to safely sit in a regular wheelchair, initiated: 11/06/2024

The "Grievance Log" complaint of 11/04/25 documented on 11/04/24 a new resident (R35) complained of being treated horribly by a transportation aide on his way to this facility. He reported he was yelled at, and cursed at several times because he kept sliding out of his wheelchair. He reported he was told, "F***, I have stopped every five miles for you, and I am not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 610	Continued From page 14	F 610		

going to keep stopping for this." R35 felt like he shouldn't be yelled at for something he could not help. He reported he slid completely out of his wheelchair and then she got really mad and started yelling. The resident also called his family and told them how he was treated. Resolution: The Transportation Aide was educated on Abuse/Neglect/Exploitation.

The "Witness Statement" from Transportation Aide O, dated 11/01/24, stated she strapped the resident (R35) in the van securely, but she had to stop several times to pull him back up in his wheelchair. He told her he was sliding himself down. The transportation aide wrote she did show some frustration with him and told herself she needed to calm down. At one point his bottom was completely off the wheelchair and she could not pull him up, so she lowered him to the floor. She called the nursing home who sent out two aides to assist her.

The "Admission Note" dated 11/04/24 at 05:21 PM documented a new male resident was transported via the facility van and wheelchair. R35 required a full lift. He leaned to his left and had no use of his left arm. R35 denied pain.

The "Progress Note" dated 11/05/24 at 05:16 AM documented R35 had not sleep at all last night. Staff assisted him with repositioning about every 30 minutes during the night shift. R35 would throw the left side of his body out of bed. The nurse finally said to him "You have to be pushing yourself this way in order for you to be off the bed like this". R35 responded, "That's what they said in the hospital." The nurse educated him on ways to better keep himself from pushing himself out of bed and he did much better after the education.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 15	F 610		

The "Progress Note," dated 11/6/24 at 04:47 AM, documented R35 continued to adjust well to the facility. R35 slid out of his wheelchair at shift change around 06:00 PM. R35 stated he slid out of his chair onto the floor and then laid down. He denied hitting his head. A complete assessment was completed along with risk management. R35 slept well all night and only rang this morning for pain medication due to left hip pain.

On 03/26/25 at 12:45 PM, R35 was lying in bed and a Broda chair with a three-inch pommel (raised area in the cushion to help prevent forward slipping) cushion was in his room. R35 was alert and oriented and reported he was verbally abused on the van ride to the facility when he was first admitted. James stated his wheelchair did not have the thing in the seat (pommel) that kept him from sliding. R35 reported the driver repeatedly got upset with him and cursed when he kept sliding forward during the ride. He reported no further problems when transported by the facility.

On 03/26/25 at 02:18 PM, Certified Nurse Aide (CNA)/Transportation Aide O, stated she took a regular wheelchair to transport the resident from the previous facility, he did not come with his own wheelchair. CNA O stated the previous facility did not give our facility any information that the resident was at risk of sliding forward. CNA O verified she was angry but had not cursed while transporting R35 in November 2024. Training for transporting residents was a class every two years with a state agency. She stated they have to demonstrate securing a resident during the class. She stated after the 11/04/24 incident the administration educated her for ANE.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 610	Continued From page 16 On 03/26/25 at 02:32 PM, Administrative Staff A verified the facility had not reported the allegation of verbal abuse to the state agency or investigated it that he knew of (he was not employed here in November). He stated the only documentation the facility could find was the Grievance Log and Transportation Aide O's note. The facility's undated "Abuse, Neglect, and Exploitation" policy stated all residents of the facility would be free of physical, emotional, and sexual abuse, neglectful treatment, and misappropriation of funds and resources. The policy stated verbal abuse included willfully disparaging and derogatory terms to residents or their families or within their hearing. Residents and their families could report a grievance orally or in writing and the Grievance Officer would immediately report the incident to the administrator of the facility. Any allegations of all types of staff-to-resident abuse would be reported to the facility administrator and to other official agencies including the State Agency. The policy stated witness statement would be obtained, an investigation performed, and a written report filed. The facility failed to thoroughly investigate the allegation of verbal abuse immediately. This placed R35 at risk for ongoing abuse and or mistreatment.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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F 622	Continued From page 17	F 622		

discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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F 622	Continued From page 18	F 622		

When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 622	Continued From page 19	F 622		

any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 13 residents. Based on the record review and interview, the facility failed to ensure that Resident (R) 126's transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving healthcare institution or provider. This placed R126 at risk for delayed treatment at the receiving institution.

Findings included:

- R126's Electronic Medical Record (EMR) recorded diagnoses of dorsalgia (discomfort occurring anywhere on the spine or back, ranging from mild to disabling), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, chronic (persisting for a long period) kidney disease, diabetes mellites (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN - elevated blood pressure), atrial fibrillation (rapid, irregular heartbeat), multiple fractures (broken bone) of ribs, low back pain and history of disease of the blood-forming organs.

The "Admission Minimum Data Set" (MDS), dated 12/12/24, documented R126 had severe cognitive impairment, verbal behavioral symptoms directed toward others, and rejection of care that occurred one to three days of the look-back period. R126 required partial/moderate assistance with toileting and personal hygiene,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 622	Continued From page 20	F 622		

upper body dressing, mobility, and transfers. R126 required substantial/maximal assistance with showering and lower body dressing. R126 had occasional incontinence of urine and received as-needed pain medication for almost constant pain, which affected sleep, therapy participation, and day-to-day activities. The MDS further documented that R126 had an unhealed stage two (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters) pressure ulcer on admission.

R126's "Care Plan" dated 12/19/24 documented R126 required staff assistance with activities of daily living related to limited mobility and physical decline. The care plan documented R126 was alert with confusion, and required assistance of one staff member with bathing, bed mobility, dressing, personal and toileting hygiene, and toilet use. The care plan further documented R126 had a stage two pressure ulcer to the middle of the spine, had the potential to be verbally aggressive towards staff, and had weight loss.

The "Progress Note" dated 12/05/24 at 04:51 PM documented that R126 had been admitted from a hospital with a self-care deficit. The progress note further documented R126 had a two cm in length by 1.5 cm width red area to the middle spine with one cm length by one cm width open dried area.

The "Progress Note" dated 12/25/24 at 02:45 PM documented R 126 found lying on the floor. The exam of R126's skin showed R126 had landed on his back, where he had an open wound. R126 was able to move all extremities without difficulty and complained of back pain. Vital signs obtained of temperature of 97.4 degrees Fahrenheit, blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 622	Continued From page 21	F 622		

pressure of 172/103, pulse 64, respiration 22, and oxygen saturation of 89 percent (%). The note further documented neurological checks initiated, the resident family member was notified, and the physician was notified by fax.

The "Progress Note" dated 12/25/24 at 11:59 PM documented R126 rested in bed with eyes closed, no further injuries found, neurological check, and vital signs were within normal limits.

The "Progress Note" dated 12/26/24 at 08:18 AM documented R126 continued with fall follow-up assessment. R126 was sleepy but easily arousable. The progress note further documented no new areas of concern and moved extremities without difficulties.

The "Progress Note" on 12/27/24 at 09:52 AM, documented that the facility received a call from the hospital that R126 was being transferred to them from the local hospital and requested information on the last given medications and treatments while R126 was at the facility. The note further documented that the facility nurse was to fax the medication and treatment administration records to the receiving hospital of R126.

The medical record lacked nursing assessment and transfer documentation as to why or how R126 left the facility.

On 03/26/25 at 02:30 PM, Administrative Nurse D verified the medical record lacked the assessment, reason, and to where R126 had been sent. Administrative Nurse D stated that the nurse who worked during that time no longer works at the facility and should have completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 622	Continued From page 22 the transfer assessments and records. The facility's "Transfers Between Facilities and Hospital" policy, dated, stated that it was the policy of the facility to expedite communication between all units of the acute hospital and the facility for the best care of the elder. Transfers between the acute hospital and the facility would be carried out efficiently and effectively. When transferring elders, these records will be sent from the facility to an acute hospital, an elder transfer and referral record must be completed in full and sent with the elder including on this record the elder's normal level of Activities of Daily Living before the illness requiring transfer to the acute hospital, copies of the most current Interdisciplinary Notes and Medication Administration Records will be sent with the elder. If the elder is sent to the Emergency Department under emergency circumstances, copies of the clinical record are to accompany the elder: the transfer record should be completed as soon as possible, along with completed nurses' notes and medication record, and sent to the acute hospital. The facility failed to ensure that the transfer/discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider which placed R126 at risk for delayed treatment in the receiving facility.	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 625	Continued From page 23	F 625		

nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 126 with an appropriate bed hold policy as required. This deficient practice placed the resident at risk of being unable to return to the facility in the same room or bed.

Findings included:

-R126's Electronic Medical Record (EMR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 625	Continued From page 24	F 625		

recorded diagnoses of dorsalgia (discomfort occurring anywhere on the spine or back, ranging from mild to disabling), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, chronic (persisting for a long period) kidney disease, diabetes mellites (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN - elevated blood pressure), atrial fibrillation (rapid, irregular heartbeat), multiple fractures (broken bone) of ribs, low back pain and history of disease of the blood-forming organs.

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R126's "Care Plan" dated 12/19/24 documented R126 required staff assistance with activities of daily living related to limited mobility and physical decline. The care plan documented R126 was alert with confusion, and required assistance of

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	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 625	Continued From page 25	F 625		

one staff member with bathing, bed mobility, dressing, personal and toileting hygiene, and toilet use. The care plan further documented R126 had a stage two pressure ulcer to the middle of the spine, had the potential to be verbally aggressive towards staff, and had weight loss.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 625	Continued From page 26	F 625		

without difficulties.

The "Progress Note" on 12/27/24 at 09:52 AM, documented that the facility received a call from the hospital that R126 was being transferred to them from the local hospital and requested information on the last given medications and treatments while R126 was at the facility. The note further documented that the facility nurse was to fax the medication and treatment administration records to the receiving hospital of R126.

The medical record lacked nursing assessment and transfer documentation as to why or how R126 left the facility.

On 03/26/25 at 02:30 PM, Administrative Nurse D verified the medical record lacked the assessment, reason, and to where R126 had been sent, and provided the bed hold form. Administrative Nurse D stated that the nurse who worked during that time no longer works at the facility and should have completed the transfer assessments and records.

The facility's undated "Bed Hold Policy" documented before this facility transfers a resident to a hospital or the resident goes on therapeutic leave, the facility will provide information to the resident and/or resident representative that specifies: the duration of the state bed-hold policy during which the resident is permitted to return and resume residency in the facility: the reserve bed payment policy in the state plan; the facility's policies regarding bed-hold period, which are consistent with the law permitting the resident to return. The nurse responsible for the preparation of information that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 625	Continued From page 27 would accompany a resident when transferred to another healthcare facility would include the facility's policy for retaining the resident's current bedroom while absent from the facility. The facility failed to provide R126's representative with a bed-hold policy. This deficient practice placed R126 at risk of being uninformed of bed-hold requirements.	F 625		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to provide an appropriate cover or dressing for Resident (R) 11's open pressure ulcer (PU) of her left heel. This deficient practice placed R11 at risk for pain or infection. Findings included:	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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F 686	Continued From page 28	F 686		

- R11's "Electronic Medical Record" documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) and left hip fracture (broken bone).

The "Quarterly Minimum Data Set" (MDS), dated 01/07/25, documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired decision-making. The MDS documented R11 required moderate staff assistance for bathing and maximum staff assistance for dressing her lower body and shoes. The MDS documented R11 had PU and PU care was provided.

R11's "Care Plan," dated 01/10/25, directed staff to monitor and document wound size, depth, granulation, and progress in healing. Notify the physician as indicated and report any signs of infection.

The "Physician Order," dated 03/25/25, directed staff to dress R11's left heel with saline-moistened promogram prisma (a wound dressing designed to maintain a moist environment and provide antimicrobial protection) to the wound bed followed by mepilex border (a self-adherent, five-layer foam dressing with a soft silicone border designed to maintain a moist wound environment, absorb drainage, and prevent pressure ulcers while minimizing pain and trauma).

On 03/25/25 at 07:42 AM, R11 finished eating 100% of her breakfast. She wore house slippers with an open back and rubber soles. R11 carried one sock. Certified Medication Aide (CMA) S took R11 to her room, used a gait belt, and transferred her to the toilet. R11 had no dressing or covering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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F 686	Continued From page 29	F 686		

on her left heel PU. CMA S requested a nurse to assess a skin tear. Administrative Staff D came to the room and left to call the wound clinic for directions on whether to apply a dressing to R11's PU. At 08:07 AM, Licensed Nurse (LN) I came in and treated the skin tear to R11's left inner calf, then assisted R11 to dress and transfer from the toilet to her wheelchair without a dressing or covering for the PU on her left heel. LN I took R11 to a recliner in the commons area and used a gait belt to transfer R11 into a recliner. LN I stated R11 had an appointment at the wound clinic at 09:00 AM and she had a shower at 06:00 AM. At 08:18 AM, LN I called the wound clinic and they directed her to cover the wound for now. LN I took R11 back to her room, cleansed the left heel wound, and applied a mepilex dressing to the wound. The PU was to the outside of the left heel, approximately two centimeters (cm) by two cm, with dry slough (dead tissue) visible. Staff were unable to determine if there had been drainage as the resident had worn fuzzy gray house slippers after her shower.

On 03/25/25 at 08:33 AM, Certified Nurse Aide (CNA) N stated R11 liked to get up early and shower around 06:00 AM. CNA N stated on shower days when the resident was to go to wound care, she had been instructed to remove the old wound dressing and inform the nurse of that.

On 03/25/25 at 10:17 AM, Administrative Nurse E verified an open wound should be covered at all times unless the physician ordered something different.

The facility failed to provide a policy for treatment of pressure ulcers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 686	Continued From page 30 The facility failed to provide an appropriate cover or dressing for R11's open PU on her left heel. This deficient practice placed R11 at risk for pain or infection.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 690	Continued From page 31	F 690		

ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 10 had physician-ordered fluid intake, which placed R10 at risk of ongoing urinary tract infections.

Findings included:

- R10's Electronic Medical Record (EMR) included diagnoses of heart failure, weakness, intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and chronic (persisting for a long period) kidney disease.

The "Quarterly Minimum Data Set" (MDS) dated 02/03/25, documented R10 had intact cognition, no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R10 required setup or clean-up assistance with eating and substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 690	Continued From page 32	F 690		

dependent on mobility and transfers. R10 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag), was incontinent of bowel, had renal (pertaining to kidneys) insufficiency, and neurogenic bladder. The MDS further documented that R10 had received oxygen, speech, occupational and physical therapy.

R10's "Care Plan," dated 02/13/25, documented R10 had a catheter in place due to a neurogenic bladder. The Care Plan directed staff to monitor and document intake and output and report to the Medical Doctor (MD) signs or symptoms of a urinary tract infection.

The "Physician Order", dated 01/29/25, ordered R10 to drink two quarts (or eight cups) of water daily (1920 cubic centimeters - cc's) every 24 hours.

The "Progress Note" dated 01/27/25 at 11:15 AM documented R10 had returned from the hospital with diagnoses of an acute urinary tract infection (UTI - an infection in any part of the urinary system), acute and chronic renal failure, and dehydration. The note further documented that R10 had an indwelling catheter due to retention.

The "Progress Note" dated 02/11/25 at 11:54 PM documented that R10 had been sent to the emergency department and had started an antibiotic due to having a urinary tract infection.

Upon review of the EMR fluid intake record from 02/24/25 to 03/12/25 (last recorded intake) revealed that R10 lacked the amount of physician-ordered intake of two quarts daily.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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F 690	Continued From page 33 On 03/26/25 at 07:54 AM, R10 sat in the dining room eating breakfast independently. R10 had two 240 cc cups with sipper lids and handles placed on the table with her meal. On 03/26/25 at 07:50 AM, Dietary Staff (DS) BB reported that the kitchen staff was not currently keeping track of anyone's fluid intake. DS BB reported that the dietary staff always placed a cup of water and a cup of juice at each meal. DS BB also stated that coffee, milk, and refills are also offered to the residents at mealtime. On 03/26/25 at 07:59 AM, Certified Medication Aide (CMA) R reported that the dietary staff kept track of fluid intake for residents who ate in the dining room, and the nursing staff kept track of the fluids for residents who chose to eat their meals in their rooms. On 03/26/25 at 09:01 AM, Licensed Nurse (LN) I stated she was not aware of the required fluid intake for R10. On 03/27/25 at 01:53 PM, Administrative Nurse D verified that R10 had a physician order of two quarts of water every 24 hours and should be included in the care plan. The facility failed to provide a urinary tract infection prevention policy. The facility failed to ensure R10 had a physician-ordered fluid intake, which placed R10 at risk of ongoing urinary tract infections.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 692	Continued From page 34	F 692		

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 10 had physician-ordered fluid intake, which placed R10 at risk of ongoing dehydration and urinary tract infections.

Findings included:

- R10's Electronic Medical Record (EMR) included diagnoses of heart failure, weakness, intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), neuromuscular dysfunction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 692	Continued From page 35	F 692		

of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and chronic (persisting for a long period) kidney disease.

The "Quarterly Minimum Data Set" (MDS) dated 02/03/25, documented R10 had intact cognition, no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R10 required setup or clean-up assistance with eating and substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and was dependent with mobility and transfers. R10 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag), was incontinent of bowel, had renal (pertaining to kidneys) insufficiency, and neurogenic bladder. The MDS further documented that R10 had received oxygen, speech, occupational and physical therapy.

R10's "Care Plan," dated 02/13/25, documented R10 had a catheter in place due to a neurogenic bladder. The Care Plan directed staff to monitor and document intake and output and report to the Medical Doctor (MD) signs or symptoms of a urinary tract infection.

The "Physician Order" dated 01/29/25 ordered R10 to drink two quarts (or eight cups) of water daily (1920 cubic centimeters - cc's) every 24 hours.

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	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 692	Continued From page 36	F 692		

The "Progress Note" dated 01/27/25 at 11:15 AM documented R10 had returned from the hospital with diagnoses of an acute urinary tract infection (UTI - an infection in any part of the urinary system), acute and chronic renal failure, and dehydration. The note further documented that R10 had an indwelling catheter due to retention.

The "Progress Note" dated 02/11/25 at 11:54 PM documented that R10 had been sent to the emergency department and had started an antibiotic due to having a urinary tract infection.

Upon review of the EMR fluid intake record from 02/24/25 to 03/12/25 (last recorded intake) revealed that R10 lacked the amount of physician-ordered intake of two quarts daily.

On 03/26/25 at 07:54 AM, R10 sat in the dining room eating breakfast independently. R10 had two 240 cc cups with sipper lids and handles placed on the table with her meal.

On 03/26/25 at 07:50 AM, Dietary Staff (DS) BB reported that the kitchen staff was not currently keeping track of anyone's fluid intake. DS BB reported that the dietary staff always placed a cup of water and a cup of juice at each meal. DS BB also stated that coffee, milk, and refills were also offered to the residents at mealtime.

On 03/26/25 at 07:59 AM, Certified Medication Aide (CMA) R reported that the dietary staff kept track of fluid intake for residents who ate in the dining room, and the nursing staff kept track of the fluids for residents who chose to eat their meals in their rooms.

On 03/26/25 at 09:01 AM, Licensed Nurse (LN) I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

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 692	Continued From page 37 stated she was not aware of the required fluid intake for R10. On 03/27/25 at 01:53 PM, Administrative Nurse D verified that R10 had a physician order of two quarts of water every 24 hours and should be included in the care plan. The facility failed to provide a urinary tract infection prevention policy. The facility's undated "Hydration" policy documented it is the policy of the facility to ensure that elders receive sufficient fluid to maintain proper hydration and health. When the elder developed a clinical condition that placed him/her at risk for dehydration, interventions acceptable and appropriate for the elder would be implemented. The facility failed to ensure R10 had a physician-ordered fluid intake, which placed R10 at risk of ongoing dehydration and urinary tract infections.	F 692		
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,	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 38	F 756		

and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§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 39 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility's consultant pharmacist failed to notify the director of nursing or R34's physician of the lack of monitoring R34's blood pressure as the physician ordered to monitor the effectiveness of her medication, placing R34 at risk of receiving unnecessary medication.

Findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 39	F 756		

- R34's "Electronic Medical Record" documented diagnoses of hypertension (HTN - elevated blood pressure), transient cerebral ischemic attack (TIA - temporary episode of inadequate blood supply to the brain), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues).

The "Quarterly Minimum Data Set" (MDS), dated 02/11/25, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R34 received antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (narcotic) medications.

R34's "Care Plan," dated 02/17/25, directed staff to consult with a pharmacist as needed, monitor, and report adverse reactions to medication therapy.

The "Physician Order," dated 08/31/24, directed staff to administer losartan (blood pressure lowering drug) 100 milligrams (mg) daily. The order stated to hold the drug if R34's systolic blood pressure (SB/P) was less than 100 mmHg (millimeters of mercury) or the diastolic blood pressure (DB/P) was less than 60 mmHg.

R34's blood pressure documentation revealed staff obtained her blood pressure weekly from 12/14/24 to 3/24/25, even though the 08/31/24 order was still active, and the resident still received the same medication.

On 03/25/25 at 11:32 AM, Certified Medication Aide (CMA) S administered medications to R34

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 756	Continued From page 40 who took the pills whole without problems. On 03/25/25 at 02:10 PM, Administrative Nurse D verified the facility's consultant pharmacist had not notified her of the blood pressure not being monitored as ordered. The facility's undated "Medication Administration," policy stated the contracted consultant pharmacist would review the elder's medication regimen monthly and document the findings and recommendations. The consultant pharmacist would communicate to the physician and those involved in the elder's care the findings, conclusions, and recommendations that result from monitoring the medication regimen. The facility's consultant pharmacist failed to notify the director of nursing or R34's physician of the lack of monitoring R34's blood pressure as the physician ordered to monitor the effectiveness of her medication, placing R34 at risk of receiving unnecessary medication.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		

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F 757	Continued From page 41 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to monitor Resident (R)34's blood pressure as the physician ordered to monitor the effectiveness of her medication. This deficient practice placed R34 at risk of receiving unnecessary medication. Findings included: - R34's "Electronic Medical Record" documented diagnoses of hypertension (HTN - elevated blood pressure), transient cerebral ischemic attack (TIA - temporary episode of inadequate blood supply to the brain), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The "Quarterly Minimum Data Set" (MDS), dated 02/11/25, documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R34 received antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (narcotic) medications.	F 757		

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F 757	Continued From page 42	F 757		

The "Care Plan," dated 02/17/25, directed staff to consult with a pharmacist as needed, monitor, and report adverse reactions to medication therapy.

The "Physician Order," dated 08/31/24, directed staff to administer losartan (blood pressure lowering drug) 100 milligrams (mg) daily. The order stated to hold the drug if R34's systolic blood pressure (SB/P) was less than 100 mmHg (millimeters of mercury) or the diastolic blood pressure (DB/P) was less than 60 mmHg.

R34's blood pressure documentation revealed staff obtained her blood pressure weekly from 12/14/24 to 3/24/25, even though the 08/31/24 order was still active, and the resident still received the same medication.

On 03/25/25 at 11:32 AM, Certified Medication Aide (CMA) S administered medications to R34 who took the pills whole without problems.

On 03/25/25 at 02:10 PM, Administrative Nurse D stated R34 switched physicians and the order from the previous physician was still in the computer. They plan to contact the current physician to verify if he wants to set parameters. She verified staff should have obtained blood pressure with the administration of losartan.

The facility's undated "Medication Administration," policy stated all medications would be administered as ordered by a physician in a safe and sanitary manner. Each elder's drug regimen would be free of unnecessary drugs, defined as: without adequate, recommended monitoring. The nursing staff would monitor the elder's response

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F 757	Continued From page 43 to medications by relevant lab values and clinical response. The facility failed to monitor R34's blood pressure as the physician ordered to monitor the effectiveness of her medication. This deficient practice placed R34 at risk of receiving unnecessary medication.	F 757		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		

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F 761	Continued From page 44	F 761		

The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to remove expired medication from use and failed to date one insulin pen when opened. This deficient practice placed residents who may have received those medications at risk for ineffective medication.

Findings included:

- On 03/24/25 at 09:07 AM, observation of the one facility medication room revealed 14 bisacodyl (laxative) suppositories with an expiration date of November 2024 and a container of aspirin/diphenhydramine (pain relief/sleep aide) 500/25 milligrams (mg) tablets, expired December 2024.

On 03/24/25 at 09:22 AM, the facility's nurse treatment cart contained an opened, undated glargine insulin pen.

On 03/24/25 at 09:07 AM, Licensed Nurse (LN) G verified the medications in the medication room were expired and she disposed of them.

On 03/24/25 at 09:22 AM, LN H verified staff should have dated the insulin pen when they opened it for use.

On 03/26/25 at 07:50 AM, Administrative Staff D verified staff were to date insulin pens when opened.

03/26/25 at 08:22 AM, Administrative Staff D stated staff were to check for expiration dates when taking medications from the medication room to place on the cart for administration.

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F 761	Continued From page 45 The facility's undated Medication Expiration and Disposal" policy stated the facility established a protocol for managing expired medications to prevent medication errors, ensure compliance with regulatory standards, and safeguard the health of residents. The facility would conduct a weekly audit of all medication inventories to identify that all medications have an expiration date, an opened-on date, and a use-by date based on manufacturer and pharmacy standards of practice. The policy stated nursing staff were responsible for checking expiration dates and use-by dates at the time of administration. The facility failed to remove expired medication from use and failed to date one insulin pen when opened. This deficient practice placed residents who may have received those medications at risk for ineffective medication.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified	F 801		

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F 801	Continued From page 46	F 801		

nutrition professional is one who-
(i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.
(ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food

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F 801	Continued From page 47	F 801		

service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 39 residents. Based on observation, interview, and record review the facility failed to provide the services of a full-time certified dietary manager for 39 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition.

Findings included:

- On 03/24/25 at 09:00 AM, observation in the facility kitchen revealed three staff working, including Dietary Staff BB who stated she was the dietary manager. She stated she started about

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F 801	Continued From page 48 three months ago, and was not certified. Dietary Staff BB stated she had just started taking the classes for Certified Dietary Manager. On 03/26/25 at 02:32 PM, Administrative Staff A verified the facility's Dietary Manager was not certified. The facility Failed to provide a policy for Qualified Dietary Managers. The facility failed to provide the services of a full-time certified dietary manager for 39 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition.	F 801		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		

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F 880	Continued From page 49	F 880		

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 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

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F 880	Continued From page 50	F 880		

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 39 residents. Based on observation, record review, and interview, the facility failed to maintain an infection monitoring surveillance plan and Enhanced Barrier Protection (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) as staff wore gown and gloves (PPE - gowns, face shields and/or eyeglasses/goggles, and gloves) in the hallway. This deficient practice placed the residents at risk for exposure to infectious processes.

Findings included:

- On 03/25/25 at 08:25 AM, Certified Nurse Aide (CNA) M wore a yellow protective gown and gloves while pushing a resident in a wheelchair to the dining room. CNA M then went to a closet next to the dining room area and opened it with the PPE on. CNA M stated she wore the gown in the hallway so that the surveyor would know what she looked like in one. CNA M then proceeded to remove the gown and gloves in the service hall next to the dining room.

On 03/26/25 at 11:30 AM, Administrative Nurse D verified the infection tracking system had not been correctly implemented before January 2025. The facility staff recognized that the infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 51	F 880		

tracking had not been correctly followed, and since January 2025, they had established an infection tracking system. Administrative Nurse D reported that the information gathered from the implemented system is reviewed at the monthly Quality Assurance meetings. Administrative Nurse D stated CNA M had been educated on the use of PPE outside of resident rooms and should not wear the PPE in the hallways.

The facility's "Enhanced Barrier Precautions (EBP)" policy dated 12/31/24, documented that the facility follows recommended guidance from the Centers for Disease Control to keep all residents from Healthcare Acquired Infections (HAI). EBPs are implemented as one intervention that this facility uses to reduce transmission of resistant organisms, which employ targeted PPE use during high-contact resident care activities. Staff will not wear the same gown and gloves for the care of more than one resident or reuse the gown and gloves for the same resident. Position a trash can inside the resident's room and near the exit for discarding PPE after removing it before exiting the room, or before providing care for another resident in the same room.

The facility's "Infection Prevention and Control Program," dated 05/11/23, documented that the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,

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F 880	Continued From page 52 visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards. The facility failed to ensure the disposal of PPE before leaving residents' rooms and to maintain an infection monitoring surveillance plan. This deficient practice placed the residents at risk of infectious disease processes.	F 880		