STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175422	A. BUILDING _____ B. WING _____	**06/29/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 26 residents. Based on interview and record review the facility failed to implement The Centers for Medicare and Medicaid Services (CMS) and The Centers for Disease Control and Prevention (CDC) recommended infection control practices to control and prevent potential spread of COVID-19 (a mild to severe respiratory illness caused by a new strain of coronavirus, characterized by fever, cough, shortness of breath) between residents and staff when the facility failed to provide a private room for Resident (R) 1, a [MEDICAL TREATMENT] (a procedure to remove toxic waste from the blood) resident, who left the facility three times a week, placing the other 25 vulnerable residents in the facility at risk for developing COVID-19. Findings included: - R1's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R1 had a Brief Interview for Mental Status (BIMS) score of 11, indicating mildly impaired cognition. The MDS recorded R1 required extensive staff assistance with bed mobility, transfers, and locomotion. The Activities of Daily Living Care Area Assessment (CAA), dated 01/16/20, recorded R1 required extensive staff assistance. The Care Plan, dated 03/04/20, documented staff transported R1 to the hospital for [MEDICAL TREATMENT] three times a week by facility van. Review of the facility resident listing revealed R1 had a roommate. On 06/29/20 at 09:15 AM, Administrative Staff A stated the facility currently had one [MEDICAL TREATMENT] resident, R1, who left the facility three times a week to receive [MEDICAL TREATMENT] at the hospital. Administrative Staff A verified R1 was not in isolation and had a roommate since 06/08/20. On 06/29/20 at 02:20 PM, Administrative Staff A stated Physician G just faxed an order to the facility directing staff to isolate R1 to a private room due to frequent trips to the hospital for [MEDICAL TREATMENT]. The facility's COVID-19 PIP policy, dated 03/13/20, documented when a resident was in the hospital and returned to the facility, he/she should be in isolation for 14 days and new admissions should be in isolation for 14 days. The facility failed to isolate R1 who left the facility three times a week for [MEDICAL TREATMENT], placing the resident's roommate and the other 25 residents in the facility at risk for possible COVID-19 infection.

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.