STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145800	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** Based on interview and record review the facility failed to implement its abuse policy to thoroughly investigate an allegation of abuse and submit a five day abuse investigation follow-up report to the state survey and certification agency for one of three residents (R1) reviewed for abuse in a sample of eight. Findings include: An Abuse and Neglect Policy dated 7/2017 states, All reports of resident abuse, neglect, and injuries of unknown origin shall be promptly and thoroughly investigated by the organization management. This policy further states that the person conducting the investigation will, at a minimum, interview the person reporting the incident, interview any witnesses to the incident, obtain witness statements in writing, and interview staff members who had contact with the resident during the alleged incident. This policy also states, The administrator will provide a written report of the results of all abuse investigations and appropriate actions taken to the state survey and certification agency within 5 (five) days. A Resident Lost or Broken Item report dated 7/2/20 documents that V15 (R1's family) reported R1's rings were missing and included a gold wedding band. This report further documents that the rings were last seen in a locked medication cart on 5/7/20. The report does not include witness statements form anyone who had access to the locked medication cart. The report documents there was an initial notification to the state survey and certification survey agency regarding the lost rings but does not include that the results of the investigation were sent to the State agency within 5 days. On 8/10/20 at 1:25p.m. V1 (Administrator) stated that V2 (Director of Nurses) and the Social Services Department conduct the abuse investigations. V1 stated that he does not have any documentation that a written report of the final outcome of the abuse investigation into R1's missing rings was sent to the state survey and certification agency within 5 days. On 8/10/20 at 1:10p.m. V10 (Social Services) stated that she conducted the investigation into R1's missing rings. V10 verified that she did not conduct any staff interviews including staff who had access to R1's rings which were locked in the medication cart. On 8/10/20 at 1:50p.m. V2 (Director of Nurses) stated that V1, who is also the abuse coordinator, delegates abuse investigations to the nursing and social services departments. V2 stated that missing items, such as R1's missing rings, are investigated by social services but that she, V2, will fax the initial and 5 day notification to the state survey and certification agency. V2 stated that the investigation into R1's missing rings was not thoroughly investigated, did not include written staff interviews, and there was no final report sent to the state survey and certification agency within 5 days.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** Based on interview and record review the facility failed to thoroughly investigate an allegation of missing rings for one of three residents (R1) reviewed for misappropriation of property in a sample of eight. Findings include: An Abuse and Neglect Policy dated 7/2017 states, All reports of resident abuse, neglect, and injuries of unknown origin shall be promptly and thoroughly investigated by the organization management. This policy further states that the person conducting the investigation will, at a minimum, interview the person reporting the incident, interview any witnesses to the incident, all witness statements will be in writing, and interviews will be conducted with staff members who had contact with the resident during the alleged incident. A Resident Lost or Broken Item report dated 7/2/20 documents that V15 (R1's family) reported R1's rings were missing which included a gold wedding band. This report further documents that R1's rings were last seen in a locked medication cart on 5/7/20. The report instructs to refer to notes for further details. The report does not include witness statements from staff who had access to the locked medication cart. R1's social services notes dated 7/1/20, which were part of R1's lost or broken item report, signed by V10 (Social Services) and V11 (Admissions), documents that R1 was missing four rings that had been placed in the locked narcotics box inside the locked medication cart on R1's hallway on 5/7/20. The note states that R1's room was searched, and dietary, laundry, and housekeeping were notified in case the rings were misplaced. The note does not document whether staff who had access to the locked narcotics box were interviewed. This note also does not include written witness statements. On 8/12/20 at 9:45a.m. V6 (Registered Nurse) stated that she regularly cared for R1 as R1's nurse. V6 stated that V15(R1's Family) notified her that R1's rings, including a wedding ring belonging to her late husband, were missing. V6 stated that another nurse told her there was a nursing progress note documenting R1's rings were taped to a card and placed in the locked narcotics box in the medication cart. V6 stated that she had never seen the rings in the narcotic box or anywhere else in the medication cart. V6 stated that someone from social services and V15 searched through R1's room and could not find the rings. V6 stated that sometime after R1's room had been searched, some of the rings were found in R1's drawer, which V6 thought seemed odd since R1's drawers had previously been searched. V6 stated R1's wedding ring was never found. V6 stated there are only a limited number of people who have access to the locked medication cart. R1's nurse's progress noted dated 5/7/20 and documented by V7 (Licensed Practical Nurse) states, 4 (four) rings laying on her (R1) table, I taped to paper and placed in (Narcotic) box at this time. On 8/10/20 at 1:10p.m. V10 (Social Services) stated that she conducted the investigation into R1's missing rings. V10 verified that she did not interview any staff who had access to R1's rings which were locked in the medication cart. V10 also stated she did not interview the nurse, V7, who documented a progress note stating V7 had placed the rings into the locked narcotics drawer of the medication cart. V10 stated that she heard from staff that some of the rings were found. V10 stated she was not aware that R1's wedding ring was not recovered. V10 stated that normally she has her investigations well organized but this time she did not. V10 stated that although the police were notified when R1's rings were noted to be missing, she believes the police were also notified that the rings were found, despite the fact that R1's wedding ring is still missing. On 8/10/20 at 1:50p.m. V2 (Director of Nurses) stated that V1 (Administrator), who is also the abuse coordinator, delegates abuse investigations to the nursing and social services departments. V2 stated that missing items, such as R1's missing rings, are investigated by social services but that she, V2, will fax the initial and 5 day notification to the state survey and certification agency. V2 stated that the investigation into R1's missing rings was not thoroughly investigated and all staff who may have had access to R1's rings while they were in the narcotics box have not been formally interviewed with written witness statements.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow a Physician's order for medication dosing for one of three residents (R1) reviewed for Physician's orders in sample of eight. Findings include: An Administering Medications policy (undated) states, The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. According to Lippincott Nursing Center's journal article from Nursing 2016, August 2016, Volume: 46 Number 8 , page 63 - 65, Nurses who don't follow the five rights (right drug, right patient, right dose, right time, right route) of medication administration can contribute to medication errors. R1's Physician's orders dated 4/23/20 document R1's Physician ordered the medication, [MEDICATION NAME] Concentrate 2 MG/ML (milligrams per milliliter) Give 1 ml sublingually

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.

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) (in the mouth under the tongue) as needed for [MEDICAL CONDITION]. Give 1ml every 15 minutes x 3 (three) until [MEDICAL CONDITION] activity ceases. R1's Physician's orders for the same date document R1 was also prescribed, [MEDICATION NAME] Concentrate 2 MG/ML. Give 0.25 ml (0.5mg) sublingually every 2 hours as needed for anxiety/agitation/restless. R1's Medication Administration Record [REDACTED]. R1's nurse's note dated 6/23/20 at 9:21p.m., and entered by V25, document that V25 accidentally administered [MEDICATION NAME] to R1 at the dose prescribed for [MEDICAL CONDITION] instead of the dose prescribed for restlessness. R1's Initial Medication Error Report dated 6/23/20 documents that V25 administered R1 the wrong dose of [MEDICATION NAME] because V25 did not completely read R1's orders for indications for use for each dose of [MEDICATION NAME]. On 8/12/20 at 10:12a.m. V2 (Director of Nurses) verified that on 6/23/20 V25 administered the wrong dose of 2mg of [MEDICATION NAME] sublingually which was ordered to treat R1's [MEDICAL CONDITION] instead of the 0.5mg of [MEDICATION NAME] ordered to treat R1's restlessness.