STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	**03/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNSET HOME	**1201 S. POLK MAYSVILLE, MO 64469**

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to report to the state survey agency when one resident (Resident #1) alleged a Certified Nursing Aide had physically abused the resident. The facility census was 51. 1. Review of the facility's Abuse Investigation Guidelines policy, dated April 2015, showed: -All events that may indicate abuse will be investigated by the Charge Nurse, Assistant Director of Nursing, Director of Nursing, or the Administrator. -Once the investigation is complete, the appropriate personnel with notify the state agency. 2. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment, a federally mandated assessment instrument completed by staff dated 12/16/19 showed: -No cognitive issues. -Independent with Activities of Daily Living (ADL's). -[DIAGNOSES REDACTED]. Review of the resident's March physician's orders [REDACTED]. During an interview on 3/25/20 at 11:30 AM, the Social Services Director (SSD) said: -On 3/16/20, Resident #1 was waiting for her when she arrived at the facility to report CNA A had hit slapped him/her through the room divider curtain several times while assisting the roommate, he/she yelled at the aide to stop, but her/she kept getting hit. He/she reported the incident to the Director of Nursing and they began investigating the allegation. After interviewing CNA A they felt the contact was not intentional and could not substantiate the allegation. The protocol for reporting allegation of abuse was to report the allegation to the charge nurse, DON or administrator and they completed investigation and reporting to the state survey agency. During an interview on 3/25/20 at 11:45 AM, Resident #1 said: - He/she was reclined in his/her recliner (the back of the recliner was situated near the room divider curtain and head of the recliner would touch the recliner when fully reclined), and Certified Nursing Aide (CNA) A was on the other side of the curtain helping his/her roommate, someone hit him/her in the head a couple of times, he/she yelled out you're hitting my head! CNA A came around the curtain and asked if he/she needed a nurse, he/she said no, and CNA A went back to helping the roommate. He/she did not have any injuries or safety concerns. During an interview on 3/26/20 at 1:00 PM, the DON said: -The SSD notified her of the allegation Resident #1 had reported, she interviewed the resident and CNA A and determined the alleged abuse was not intentional and reported her findings to the administrator. She reports her investigation findings to the administrator and the administrator reviews it and takes care of reporting to state survey agency. During an interview on 3/26/20 at 1:15 PM, CNA A said: -She was in Resident #1's room helping his/her roommate get out of bed to use the restroom, he/she heard Resident #1 yelling his/her roommate's name and was saying stop, you're hitting my head she went around the curtain and told Resident #1 it was not his/her roommate who had hit him/her, she was helping the roommate get out of bed and she was the one who had hit him/her, she said she apologized and offered to get the charge nurse to check him/her out, the resident refused. She said she remained with the resident for a while to make sure he/she was doing well and then went back to assisting the roommate. She did not report the incident to the charge nurse. During an interview on 3/26/20 at 1:30 PM, the Facility Administrator said: - The DON reported the incident to her, they did not report the allegation because they felt the allegation of abuse was not intentional, but in hindsight she knows she should have contacted the corporate nurse and reported the allegation to the state survey agency. MO 268

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