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 _____	09/08/2020

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 14 residents with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to notify the physician for one of six sampled residents, Resident (R) 11's low blood sugars. Findings included: - R11's Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had intact cognition and required limited staff assistance with bed mobility, transfers, and toileting. The MDS documented the resident received insulin (a hormone produced in the pancreas that regulates the amount of glucose (sugar) in the blood) seven days in the lookback period. The Diabetes Mellitus Care Plan, dated 08/06/20, directed staff to administer medication as physician ordered, educate the resident on complications of the disease, obtain fasting blood sugars as ordered, and educate the resident to the correct protocol for glucose monitoring. The care plan lacked direction to staff on the signs and symptoms of [DIAGNOSES REDACTED] and when to notify the physician. The Physician Order, dated 07/03/20, directed staff to check the resident's blood sugar before meals and at bedtime, and report to the physician if the resident's blood sugar was below 60 milligrams/deciliter (mg/dl) or above 450 mg/dl. The Nurse's Note, dated 07/14/20 at 09:15 PM, documented the resident had a blood sugar of 41 mg/dl at 08:15 PM. Staff observed the resident in her chair, slumped over and visibly sweating. The resident was lethargic but able to arouse when staff called her name. The nurse administered the resident two boxes of orange juice and obtained a blood sugar reading of 60 mg/dl after 15 minutes. The note further documented the resident ate half of her supper and requested iced tea with sugar. Staff obtained the resident's blood sugar 45 minutes after the initial reading and recorded a reading of 93 mg/dl. Review of R11's medical record lacked documentation staff notified the physician of R11's low blood sugar. The Nurse's Note, dated 08/11/20 at 12:35 AM, documented at 10:45 PM the resident had a low blood sugar reading and staff started to administer the resident glucose with little success due to the resident fighting staff. The note documented staff notified Emergency Medical Services (EMS) for assistance as the resident had fluids coming out of her nose and staff were uncertain if she had aspirated. The Nurse's Note, dated 08/11/20 at 02:41 AM, documented the resident returned from the hospital after she received potassium and directed staff to have the resident drink more water. The Nurse's Note, dated 08/11/20 at 08:13 AM, documented the resident complained of being cold and shaky. The note further documented the resident was alert, confused, and her blood sugar was 99 mg/dl. The Nurse's Note, dated 08/12/20 at 12:27 AM, documented the resident was hypoglycemic (low blood sugar) with a fasting blood sugar in the 20's mg/dl last evening, unable to follow directions, and take in any interventions orally, such as glucose tabs (sugar tablets) or orange juice. The note further documented the facility requested parameters for reporting low/high fasting blood sugars and an order for [REDACTED]. The order further directed staff to recheck the resident's blood sugar and repeat if still below 70 mg/dl. Once above 70 mg/dl, follow-up with a snack. If the blood sugar was 60 mg/dl or below and the resident unable to follow commands or safely swallow, administer [MEDICATION NAME], 1 mg, subcutaneous one time. The order may be repeated every 15 minutes as needed and contact the provider or call if [MEDICATION NAME] was administered. Report blood sugars above 450 mg/dl to provider or on call physician. On 09/02/20 at 10:30 AM, observation revealed the resident lying on her bed with eyes closed. On 09/08/20 at 09:15 AM, Certified Nurse Aide (CNA) M stated the resident ate in her room most of the time and had not seen the resident when she exhibited blood sugar problems. On 09/08/20 at 09:30 AM, Licensed Nurse (LN) G stated staff should have obtained the resident's blood sugar parameters upon admission to help staff know what to do when her blood sugars dropped. On 09/08/20 at 12:10 PM, Administrative Nurse D stated staff should have contacted the physician upon admission to clarify the resident's blood sugar parameters and what to do when she had a hypoglycemic crisis. The facility's undated Nurse Notification of Physician, Resident and Representative of Changes policy, documented it was the responsibility of licensed nurses employed at the facility to notify the resident's physician/designee, the resident and the representative if/when the resident's clinical condition may require or requires physician intervention or potential for physician intervention, or a significant change in the resident's physical, mental or psychosocial status. The facility failed to notify R11's physician of the residents low blood sugars, placing the resident at risk for further blood sugar issues.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 14 residents. Based on observation, interview, and record review, the facility failed to investigate Resident (R) 8's 5.5 inch (in) x 2 in bruise of unknown origin. Findings included: - R8's Physicians Order Sheet, dated 07/02/20, documented [DIAGNOSES REDACTED]. R8's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had moderately impaired cognition, required extensive assistance of two staff for bed mobility, repositioning, transfers, and functional impairment in lower extremities. The MDS lacked any documented bruises or skin tears. The Activities of Daily Living (ADL) Care Area Assessment (CAA), dated 04/09/20, documented the resident required extensive assistance of two staff with transfers, ambulated with a gait belt and front wheeled walker, and independently propelled her wheelchair. The CAA documented the resident had behavioral symptoms at times due to her [DIAGNOSES REDACTED]. The ADL Care Plan, dated 04/13/20, recorded the resident required one to two staff to transfer the resident, one to two staff for repositioning and bed mobility, and provide a pressure relieving/reducing mattress to protect skin while in bed. The care plan recorded the resident at high risk for skin injury and directed staff to educate family and caregivers of causative factors and measures to prevent skin injury. The Progress Note, dated 06/10/20 at 02:35 PM, documented staff noted bruising on resident's left upper arm. The area measured 5.5 in x 2 in and the resident stated staff pulled on her arms when she fell on [DATE]. On 09/03/20 at 11:50 AM, observation revealed the resident sat in a recliner and staff assisted her to eat lunch. On 09/08/20 at 02:30 PM, Administrative Nurse D verified the resident had an bruise of unknown origin that was documented in the nurse's note and verified the facility lacked a follow up and investigation. On 09/08/20 at 02:30 PM, Administrative Staff A verified the facility did not investigate the resident's bruise of unknown origin. The facility's undated Abuse, Neglect and Exploitation policy documented injuries of unknown origin are to be promptly investigated to determine the probable cause of the injury. The policy documented each resident would be free from abuse, neglect, and misappropriation of the resident's property and exploitation. Abuse may include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion and any physical or chemical restraint. The facility failed to investigate R8's left upper arm skin tear of unknown origin, placing the resident at risk for further injury.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to revise two of 14 sampled resident's care plans to include interventions to prevent a pressure ulcer for Resident (R) 4, and blood sugar parameters for R11. Findings included: - R4's Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition and required extensive staff assistance with bed mobility, transfers, toileting, dressing, and personal hygiene. The MDS documented the resident at risk for pressure ulcers and no pressure relieving devices for her bed and chair. The Pressure Ulcer Care Area Assessment (CAA), dated 06/19/20, documented the resident at risk for pressure ulcer development due to limited mobility and incontinence. The Skin Integrity Care Plan, dated 04/01/20, directed staff to encourage good nutrition and hydration to promote healthier skin. The care plan lacked interventions to prevent skin breakdown. The Braden Scale Assessment, dated 012/21/19, documented a score of 12, indicating high risk to develop pressure ulcers. The Braden Scale Assessment, dated 03/21/20, documented a score of 14, indicating a moderate risk for pressure ulcers. The Mini Nutritional Assessment, dated 07/08/20, documented the resident had a moderate decrease in food intake and severe dementia. The Skin Observation Tool, dated 07/10/20, documented the resident's coccyx (a small triangular bone at the base of the spine) with a 1 centimeter (cm) x 1 cm reddened area classified as a Stage 2 pressure ulcer (partial thickness skin loss involving the dermis. May present as an open blister or shallow crater). R4's Physician Order, dated 07/11/20, directed staff to apply [MEDICATION NAME] (an absorbent dressing) on the resident's coccyx every three days and as needed. The Skin Observation Tool, dated 08/21/20, documented the resident's coccyx reddened. The Skin Observation Tool, dated 09/04/20, documented no new skin breakdown. On 09/08/20 at 10:18 AM, observation revealed the resident's coccyx with a small pink shallow area, approximately the size of a dime, with red skin surrounding the wound. Licensed Nurse (LN) G applied skin prep (antimicrobial skin cleanser) around the wound and the resident stated it burned. LN G fanned the area to help it dry quickly and placed a [MEDICATION NAME] adhesive bandage (highly absorbent cotton fabric bonded on both sides with a perforated non-adherent film) on the area. On 09/08/20 at 10:00 AM, Certified Nurse Aide (CNA) M stated staff repositioned the resident every two hours to keep her off her bottom. On 09/08/20 at 10:20 AM, LN G stated the wound was almost healed but staff applied the bandage for protection. On 09/08/20 at 12:15 PM, Administrative Nurse D stated the resident should have had interventions in place to prevent skin breakdown on her care plan. Upon request, the facility did not provide a policy for care plan revision. The facility failed to revise R4's care plan for interventions to prevent a Stage 2 pressure ulcer, placing the resident at risk for further skin breakdown. - R11's Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had intact cognition and required limited staff assistance with bed mobility, transfers, and toileting. The MDS documented the resident received insulin (a hormone produced in the pancreas that regulates the amount of glucose (sugar) in the blood) seven days of the lookback period. The Diabetes Mellitus Care Plan, dated 08/06/20, directed staff to administer medication as physician ordered, educate the resident on complications of the disease, obtain fasting blood sugars as ordered, and educate the resident to the correct protocol for glucose monitoring. The care plan lacked direction to staff on the signs and symptoms of [DIAGNOSES REDACTED] and when to notify the physician. The Physician Order, dated 07/03/20, directed staff to check the resident's blood sugar before meals and at bedtime, and report to the physician if the resident's blood sugar was below 60 milligrams/deciliter (mg/dl) or above 450 mg/dl. The Nurse's Note, dated 07/14/20 at 09:15 PM, documented the resident had a blood sugar of 41 mg/dl at 08:15 PM. Staff observed the resident in her chair, slumped over and was visibly sweating. The resident was lethargic but able to arouse when staff called her name. The nurse administered the resident two boxes of orange juice and obtained a blood sugar reading of 60 mg/dl after 15 minutes. The note further documented the resident ate half of her supper and requested iced tea with sugar. Staff obtained the resident's blood sugar 45 minutes after the initial reading and recorded a reading of 93 mg/dl. Review of R11's medical record lacked documentation staff notified the physician of R11's low blood sugar. The Nurse's Note, dated 08/11/20 at 12:35 AM, documented at 10:45 PM the resident had a low blood sugar reading and staff started to administer the resident glucose with little success due to the resident fighting staff. The note documented staff notified Emergency Medical Services (EMS) for assistance as the resident had fluids coming out of her nose and staff were uncertain if she had aspirated. The Nurse's Note, dated 08/11/20 at 02:41 AM, documented the resident returned from the hospital after she received potassium and directed staff to have the resident drink more water. The Nurse's Note, dated 08/11/20 at 08:13 AM, documented the resident complained of being cold and shaky. The note further documented the resident was alert, confused, and her blood sugar was 99 mg/dl. The Nurse's Note, dated 08/12/20 at 12:27 AM, documented the resident hypoglycemic with a fasting blood sugar in the 20's mg/dl last evening, unable to follow directions, and take in any interventions orally, such as glucose tabs (sugar tablets) or orange juice. The note further documented the facility requested parameters for reporting low/high fasting blood sugars and an order for [REDACTED]. The order further directed staff to recheck the resident's blood sugar and repeat if still below 70 mg/dl. Once above 70 mg/dl, follow-up with a snack. If the blood sugar was 60 mg/dl or below and the resident unable to follow commands or safely swallow, administer [MEDICATION NAME], 1 mg, subcutaneous one time. The order may be repeated every 15 minutes as needed and contact the provider or call if [MEDICATION NAME] was administered. Report blood sugars above 450 mg/dl to provider or on call physician. On 09/02/20 at 10:30 AM, observation revealed the resident lying on her bed with eyes closed. On 09/08/20 at 09:15 AM, Certified Nurse Aide (CNA) M stated the resident ate in her room most of the time and had not seen the resident when she exhibited blood sugar problems. On 09/08/20 at 09:30 AM, Licensed Nurse (LN) G stated staff should have obtained the resident's blood sugar parameters upon admission to help staff know what to do when her blood sugars dropped. On 09/08/20 at 12:10 PM, Administrative Nurse D stated staff should have contacted the physician upon admission to clarify the resident's blood sugar parameters, and the care plan should have been revised to direct staff on what to do when she had a hypoglycemic crisis. Upon request, the facility did not provide a policy for revision of care plans. The facility failed to revise R11's care plan with blood sugar parameters, placing the resident at risk for further blood sugar issues.
F 0676 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 14 residents with eight reviewed for Activities of Daily Living (ADLs). Based on observation, record review, and interview, the facility failed to provide bathing services as care planned for one of eight sampled residents, Resident (R) 8. Findings included: - R8's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had moderately impaired cognition, required extensive assistance of two staff for personal hygiene and grooming, and required physical help with bathing. The ADL Care Plan, dated 04/13/20 directed one staff to provide the resident assistance with bathing and the resident enjoyed whirlpools. R8's Bathing Report and bath sheets documented the resident preferred a whirlpool on Monday evening shift and Thursday day shift. The July Bathing Report and bath sheets documented the resident received a whirlpool the following dates: 07/13/20 07/24/20 - 10 days no whirlpool 07/27/20 The August Bathing Report and bath sheets documented the resident received a whirlpool the following dates: 08/10/20 - 13 days no whirlpool 08/14/20 08/21/20 - 6 days no whirlpool 08/27/20 09/07/20- 10 days no whirlpool On 09/03/20 at 11:50 AM, observation revealed the resident sat in her recliner dressed in street clothes and hair uncombed. On 09/03/20 at 02:30 PM, Administrative Nurse D verified the residents had scheduled bath/shower days and the aides documented in the electronic health records and on bath sheets, and felt the resident received a whirlpool but they were not documented properly. The facility's undated Assisting an Elder with a Spa Bath or Whirlpool Bath policy, documented all elder's residing in the facility would receive care, treatment and services according to the elders individualized care plan. Based on the individual elder's comprehensive assessment, staff would ensure that each elder's abilities in activities of daily living include bathing would not diminish unless circumstances of the elder's clinical condition demonstrated that the decline was unavoidable. The policy further documented staff report to licensed nurse and observation of the elder's skin or other concerns noted during the bathing procedure and document completion of the shower in the elder's clinical record. The facility failed to provide the necessary care and bathing services for R8, placing the resident at risk for poor hygiene.
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.**

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 14 residents with eight reviewed for Activities of Daily Living (ADLs). Based on observation, record review, and interview, the facility failed to provide bathing services as care planned for one of eight sampled residents, Resident (R) 17. Findings included: - R17's Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition, and required extensive assistance of two staff for personal hygiene, grooming, and total dependence of two staff for bathing. The ADL Care Plan, dated 02/25/20 directed two staff to provide the resident assistance at least part of bathing. R17's Bathing Report and bath sheets documented the resident preferred a shower on Monday and Thursday evening shift. The July Bathing Report and bath sheets documented the resident received a shower on the following days: 07/13/20 07/21/20 - 7 days no shower 07/24/20 The August Bathing Report and bath sheets documented the resident received a shower on the following days: 08/11/20 -17 days no shower 08/21/20 - 9 days no showers 08/24/20 09/07/20 -13 days no shower On 09/03/20 at 11:50 AM, observation revealed the resident sat in his wheelchair in the living room dressed in street clothes wearing a mask. On 09/03/20 at 02:30 PM, Administrative Nurse D verified the residents had scheduled bath/shower days and the aides documented in the electronic health records and on bath sheets, and felt the resident received a whirlpool but they were not documented properly. The facility's undated, Assisting an Elder with a Spa Bath or Whirlpool Bath policy, documented all elder's residing in the facility would receive care, treatment and services according to the elders individualized care plan. Based on the individual elder's comprehensive assessment, staff would ensure that each elder's abilities in activities of daily living include bathing would not diminish unless circumstances of the elder's clinical condition demonstrated that the decline was unavoidable. The policy further documented staff report to licensed nurse and observation of the elder's skin or other concerns noted during the bathing procedure and document completion of the shower in the elder's clinical record. The facility failed to provide the necessary care and bathing services for R17, placing the resident at risk for poor hygiene.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 14 residents with three reviewed for pressure ulcers. Based on observation, record review, and interview, the facility failed to provide interventions to prevent the development of a facility acquired pressure ulcer for one of three sampled residents, Resident (R) 4. Findings included: - R4's Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the resident had severely impaired cognition and required extensive staff assistance with bed mobility, transfers, toileting, dressing, and personal hygiene. The MDS documented the resident at risk for pressure ulcers and had no pressure relieving devices for her bed and chair. The Pressure Ulcer Care Area Assessment (CAA), dated 06/19/20, documented the resident at risk for pressure ulcer development due to limited mobility and incontinence. The Skin Integrity Care Plan, dated 04/01/20, directed staff to encourage good nutrition and hydration to promote healthier skin. The care plan lacked interventions to prevent skin breakdown. The Braden Scale Assessment, dated 12/21/19, documented a score of 12, indicating high risk to develop pressure ulcers. The Braden Scale Assessment, dated 03/21/20, documented a score of 14, indicating a moderate risk for pressure ulcers. The Mini Nutritional Assessment, dated 07/08/20, documented the resident had a moderate decrease in food intake and had severe dementia. The Skin Observation Tool, dated 07/10/20, documented the resident's coccyx (a small triangular bone at the base of the spine) with a 1 centimeter (cm) x 1 cm reddened area classified as a Stage 2 pressure ulcer (partial thickness skin loss involving the dermis. May present as an open blister or shallow crater). R4's Physician Order, dated 07/11/20, directed staff to apply [MEDICATION NAME] (an absorbent dressing) on the resident's coccyx every three days and as needed. The Skin Observation Tool, dated 08/21/20, documented the resident's coccyx reddened. The Skin Observation Tool, dated 09/04/20, documented no new skin breakdown. On 09/08/20 at 10:18 AM, observation revealed the resident's coccyx with a small pink shallow area, approximately the size of a dime, with red skin surrounding the wound. Licensed Nurse (LN) G applied skin prep (antimicrobial skin cleanser) around the wound and the resident stated it burned. LN G fanned the area to help it dry quickly and placed a [MEDICATION NAME] adhesive bandage (highly absorbent cotton fabric bonded on both sides with a perforated non-adherent film) on the area. On 09/08/20 at 10:00 AM, Certified Nurse Aide (CNA) M stated staff repositioned the resident every two hours to keep her off her bottom. On 09/08/20 at 10:20 AM, LN G stated the wound was almost healed and staff applied a bandage on the wound for protection. On 09/08/20 at 12:15 PM, Administrative Nurse D stated the resident should have had interventions in place to prevent skin breakdown. Upon request, the facility did not provide a policy for prevention of pressure ulcers. The facility failed to implement effective interventions to prevent a facility acquired pressure ulcer for cognitively impaired dependent R4, identified at risk for pressure ulcers, placing the resident at risk for further skin breakdown.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** The facility had a census of 25 residents. Based on observation, record review, and interview, the facility failed to ensure the environment remained free of accident hazards when chemicals were not locked in a secure area. Findings included: - On 09/01/20 at 10:35 AM, observation during the initial tour revealed an unlocked janitor closet on the North 100 Hall. The following items were observed in the closet: One- 32 ounce (oz) bottle of glass cleaner, with the warning label keep out of reach of children and pets, avoid contact with skin, eyes, and clothing. One-32 oz container of(NAME)Pro Appearance 25, high solid floor finisher, with the warning label keep out of reach of children, may cause skin, eye irritation, harmful if swallowed, inhalation of vapors or mist may cause respiratory problems. One-32 oz container of(NAME)Pro Concur-No Rinse Neutral cleaner, with the warning label, may cause skin and eye irritation. One-32 oz container of C.U.I. disinfectant and deodorizer cleaner, with the warning label, keep out of reach of children,hazards to humans and domestic animals. Causes irreversible eye damage, and skin burns, and harmful if swallowed. On 09/01/20 at 10:40 AM, Housekeeping Staff (HS) U verified the janitor closet should be locked, the chemicals and products with the warning labels should be stored in a locked room, and stored out of reach of the residents. On 09/09/20 at 08:00 AM, Administrative Staff A verified the facility had four cognitively impaired, independently mobile residents. The facilities undated Control of Hazardous Chemicals policy, documented the facility is committed to eliminating and controlling hazards that could cause injury or illness to the elders, employees, vendors, volunteers, and visitors. The facility will meet the requirements of safety standards where there are specific rules about hazards or potential hazards in the facility. All containers of hazardous chemicals in each workplace would be conspicuously labeled with the identity of the chemical and the appropriate hazard warnings. All substance with warning labels, including but not exclusive to Keep out of reach of children, will always be locked and inaccessible. All hazardous chemicals are always to be locked to avoid accessibility of any elder in the facility. The facility failed to ensure chemicals were kept in a locked room, placing the four cognitively impaired, independently mobile residents, who resided in the facility, at risk for injury.
F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 25 residents. The sample included 14 residents with five reviewed for nutrition. Based on observation, record review, and interview, the facility failed to develop and implement effective nutritional interventions for one of five sampled residents, Resident (R) 17, who had a weight loss of 10.39% or 15.6 pounds (lbs) in six months. Findings included: - R17's Physician order [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], recorded the resident had a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. The MDS recorded the resident required supervision with oversight, encouragement, or cueing, with eating. The Nutrition Care Area Assessment (CAA), dated 11/25/19, documented the resident fed himself, and ate a regular mechanical soft ground meat diet with thickened liquids. The CAA documented the resident weighed 152.4 lbs, 68 inches tall, and received [MEDICATION NAME] (a medication to treat depression and anxiety, and increased weight). The Nutrition Care Pan, dated 02/25/20, documented the resident had a potential nutritional problem due to the diet ordered. The care plan directed staff to serve the diet ordered, monitor intake and record every meal. Registered Dietician (RD) to evaluate and make diet change recommendations as needed. R17's Vital Signs- Weights documented the following weights: 12/17/19 - 150.2 lbs. 1/20 - no weight recorded

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F 0692 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 3) 02/04/20 - 143.2 lbs. 03/12/20 - 140.4 lbs. 04/10/20 - 136.0 lbs. 05/18/20 - 138.2 lbs. 06/03/20 - 135.2 lbs. 07/09/20 - 134.4 lbs. 07/12/20 - 134.6 lbs. 08/20/20 - 132.6 lbs. (loss of 15.6 lbs. or 10.39 % in six months) 09/07/20 - 131.4 lbs. (loss of 18.8 lbs. or 12.52 % in seven months) The Meal Intake Log from 08/11/20 until 09/09/20 documented the resident had a total of 90 meals, with the following intakes: 22 meals at 0-25% 10 meals at 26-50% 26 meals at 51-75% 32 meals at 76-100% The Physician Order, dated 08/23/18, directed staff to administer a regular diet, mechanical soft texture, and nectar (liquids easily pourable consistency). The RD Assessment, dated 11/16/19, documented the resident's current weight was 152.0 lbs which was stable. The assessment documented the resident received [MEDICATION NAME], with a side effect of weight gain and [MEDICATION NAME] (fluid medication) 20 milligrams (mg) which could cause some weight fluctuations. The assessment documented the resident received a regular diet with mechanical soft texture and nectar thick liquids. The assessment directed staff to monitor the resident's weight trends with a goal for weight maintenance and no significant weight changes. The Physician Order, dated 02/19/20, directed staff to administer an in house supplement, twice daily for increased calorie and to prevent weight loss. The Physician Order, dated 08/20/20, directed staff to administer an in house supplement, three times a day for increased calories. The RD Assessment, dated 08/21/20, documented the resident's annual current weight was 132.0 lbs, down 2 lbs in one month, 4.3 lbs in three months, and 6 lbs in six months. The assessment documented the resident's weight had been trending down over the past six months, no significant weight changes, diet was regular with intakes averaging 50-75% of meals and increased the supplement from two to three times a day on 08/02/20. The assessment directed staff to monitor the resident's weight trends with a goal for gradual weight gain and no significant weight changes and refer to the RD as needed. On 09/03/20 at 07:55 AM, observation revealed the resident sat in his wheelchair in the living room dressed in street clothes and drank all of his vanilla nutritional supplement. On 09/03/20 at 11:35 AM, the resident sat in a wheelchair at the dining room table with mechanical soft chicken fried steak, mashed potatoes, gravy, and harvest beets. Continued observation revealed the resident independently ate approximately half of the meal. On 09/08/20 at 01:10 PM, Administrative Nurse B stated the resident had a weight loss of 15.6 lbs in six months, would review the RD's assessments, and reassess the resident's nutritional needs. On 09/09/20 at 03:30 PM, Certified Dietary Manager (CDM) BB verified the resident lost 18.8 lbs since 12/17/19. CDM BB stated she recommended a speech therapy assessment in August 2020. CDM BB stated the resident had recently been mixing his food and not eating it, and continued to lose weight. CDM BB stated she would recommend staff sit with the resident to cue and assist him to eat. On 09/09/20 at 04:10 PM, Consultant (C) GG verified the resident lost 18.8 lbs since 12/17/19. C GG recorded she evaluated the resident's weight loss, and on 02/16/20 recommended in house supplement twice daily. The 05/24/20 review recorded the resident's weight stable and made no recommendations. The 08/21/20 review recorded a weight loss and she recommended to increase the in house supplement to three times a day. C GG verified she would recommend staff provide the resident with a scoop of ice cream three times a day. C GG verified she would add new interventions for the resident to receive staff assistance with eating due to his forgetfulness. On 09/10/20 at 11:25 AM, Administrative Nurse D verified the facility identified weight loss and interventions at risk meetings, however they have not had any meetings since March 2020 due to personnel changes. Administrative Nurse D verified the present system to identify weight loss was C GG would review the resident's weight at least monthly and send an email to the facility with recommendations and interventions. Upon request the facility did not provide a policy for Weight Assessment, Interventions or Loss. The facility failed to implement timely and effective interventions to prevent weight loss for R17, who lost 15.6 pounds (10.39 % in six month), resulting in significant weight loss, placing the resident at risk for increased health concerns.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census 25 residents. The sample included 14 residents with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to obtain blood sugar parameters for one of six sampled residents, Resident (R) 11, who had a hypoglycemic crisis (condition resulting when the blood glucose levels drop below the specified limits). Findings included: - R11's Physician order [REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], documented the resident had intact cognition and required limited staff assistance with bed mobility, transfers, and toileting. The MDS documented the resident received insulin (a hormone produced in the pancreas that regulates the amount of glucose (sugar) in the blood) seven days of the lookback period. The Diabetes Mellitus Care Plan, dated 08/06/20, directed staff to administer medications as physician ordered, educate the resident on complications of the disease, obtain fasting blood sugars as ordered, and educate the resident to the correct protocol for glucose monitoring. The care plan lacked direction to staff on the signs and symptoms of [DIAGNOSES REDACTED] and when to notify the physician. The Physician Order, dated 07/03/20, directed staff to check the resident's blood sugar before meals and at bedtime, and report to the physician if the resident's blood sugar was below 60 milligrams/deciliter (mg/dl) or above 450 mg/dl. The Nurse's Note, dated 07/14/20 at 09:15 PM, documented the resident had a blood sugar of 41 mg/dl at 08:15 PM. Staff observed the resident in her chair, slumped over and visibly sweating. The resident was lethargic but able to arouse when staff called her name. The nurse administered the resident two boxes of orange juice and obtained a blood sugar reading of 60 mg/dl after 15 minutes. The note further documented the resident ate half of her supper and requested iced tea with sugar. Staff obtained the resident's blood sugar 45 minutes after the initial reading and recorded a reading of 93 mg/dl. Review of R11's medical record lacked documentation staff notified the physician of R11's low blood sugar. The Nurse's Note, dated 08/11/20 at 12:35 AM, documented at 10:45 PM the resident had a low blood sugar reading and staff started to administer the resident glucose with little success due to the resident fighting staff. The note documented staff notified Emergency Medical Services (EMS) for assistance as the resident had fluids coming out of her nose and staff were uncertain if she had aspirated. The Nurse's Note, dated 08/11/20 at 02:41 AM, documented the resident returned from the hospital after she received potassium and directed staff to have the resident drink more water. The Nurse's Note, dated 08/11/20 at 08:13 AM, documented the resident complained of being cold and shaky. The note further documented the resident was alert, confused, and her blood sugar was 99 mg/dl. The Nurse's Note, dated 08/12/20 at 12:27 AM, documented the resident was hypoglycemic (low blood sugar) with a fasting blood sugar in the 20's mg/dl last evening, unable to follow directions, and take in any interventions orally, such as glucose tabs (sugar tablets) or orange juice. The note further documented the facility requested parameters for reporting low/high fasting blood sugars and an order for [REDACTED]. The order further directed staff to recheck the resident's blood sugar and repeat if still below 70 mg/dl. Once above 70 mg/dl, follow-up with a snack. If the blood sugar was 60 mg/dl or below and the resident unable to follow commands or safely swallow, administer [MEDICATION NAME], 1 mg, subcutaneous one time. The order may be repeated every 15 minutes as needed and contact the provider or call if [MEDICATION NAME] was administered. Report blood sugars above 450 mg/dl to provider or on call physician. On 09/02/20 at 10:30 AM, observation revealed the resident lying on her bed with eyes closed. On 09/08/20 at 09:15 AM, Certified Nurse Aide (CNA) M stated the resident ate in her room most of the time and had not seen the resident when she exhibited blood sugar problems. On 09/08/20 at 09:30 AM, Licensed Nurse (LN) G stated staff should have obtained the resident's blood sugar parameters upon admission to help staff know what to do when her blood sugars dropped. On 09/08/20 at 12:10 PM, Administrative Nurse D stated staff should have contacted the physician upon admission to clarify the resident's blood sugar parameters and what to do when she had a hypoglycemic crisis. Upon request, the facility did not provide a policy for blood sugar parameters. The facility failed to obtain blood sugar parameters for R11, who had two hypoglycemic crises, placing the resident at risk for further blood sugar issues.
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 25 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of diseases and infection for three residents who received oxygen therapy, Residents (R) 2, R10, R26, and for cleaning an isolation room without the appropriate protective gown. Findings included: - On 09/02/20 at 09:00 AM, observation during initial tour revealed R26's nasal cannula and tubing unbagged and wrapped around the resident's oxygen canister next to the resident's bed. On 09/03/20 at 08:30 AM, observation revealed R26's nasal cannula and tubing attached to the concentrator, unbagged and placed in the resident's recliner seat. On 09/04/20 at 08:50 AM, observation revealed R26's nasal cannula and tubing unbagged and wrapped around the resident's oxygen canister next to the resident's bed. On 09/08/20 at 08:30 AM, observation revealed R2's nasal cannula and tubing unbagged and wrapped around the resident's oxygen canister in the corner of her room. On 09/08/20 at 08:35 AM, observation revealed R10's nasal cannula and tubing unbagged and rolled up on top of the residents oxygen concentrator. On 09/08/20 at 08:40 AM, observation revealed R26's nasal

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 _____	**09/08/2020**

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) cannula and tubing attached to the concentrator, unbagged and placed in the resident's recliner seat. On 09/08/2020 at 08:45 AM, Licensed Nurse (LN) H verified the oxygen cannula and tubing should be in a bag when not in use. Upon request, the facility did not provide a policy for Oxygen storage. The facility failed to properly store R2, R10, and R26's oxygen therapy equipment when not in use, placing the residents at risk for infection. - On 09/03/20 at 08:05 AM, observation revealed Housekeeping Staff (HS) U in Isolation room [ROOM NUMBER] to clean after a resident was taken off of isolation precautions and moved to another room. HS U entered the room and began cleaning without wearing a protective gown. Further observation revealed HS U placed the soiled yellow isolation gowns into a red bag, carried them out of the room, down the hall, and went outside. On 09/03/20 at 08:30 AM, observation revealed HS U returned to Isolation room [ROOM NUMBER] without wearing a protective gown, took down the privacy curtain and window valance (form of window treatment that covers the uppermost part of the window and can be hung alone or paired with window blinds, or curtains), and placed them in a clear bag. Further observation revealed HS U took the box of medical disposable gloves out of the room, placed them on her cart, and applied a pair of gloved from the box. On 09/03/20 at 09:25 AM, observation revealed Certified Nurse Aide (CNA) M entered Isolation room [ROOM NUMBER] without a protective gown on and removed the container of sani wipes (sanitizer wipes) out of the dirty room and placed them on the top of another isolation room personal protective equipment (PPE) cart. On 09/03/20 at 09:30 AM, CNA M stated she should have worn a protective gown when she went into Isolation room [ROOM NUMBER] and should not have taken the sani wipes from one isolation room to another isolation room PPE cart. On 09/03/20 at 09:35 AM, HS U stated she should have worn a protective gown while cleaning the dirty isolation room. On 09/08/20 at 12:10 PM, Administrative Nurse D stated, anyone entering an isolation room should wear a protective gown unless the room had been cleaned and empty. Administrative Nurse D further stated the sani wipes should not have been put on another isolation PPE cart after being in another isolation room. The facility's undated Infection Control policy documented the facility would facilitate safe care of all residents and staff with known or suspected communicable disease by establishing and maintaining 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. The policy applied to all staff members from all departments of this facility, residents residing in the facility, visitors of the facility, volunteers of facility, contracted and vendors of facility. Upon discharge of an isolation room, all unused disposable items will be discarded, all non disposable items including furnishings will be cleaned with an EPA approved sanitizer that has been approved by the manufacturer of the product to effectively kill the identified microorganism. The facility failed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection when staff failed to wear PPE upon entering/cleaning an isolation room, placing the residents at risk for infection.