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 _____	C 10/30/2018

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 citation represents the findings of complaint investigation #133461.	F 000		
F 880 SS=D	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 arrangement based upon the facility assessment conducted according to §483.70(e) 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	F 880		

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
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F 880	Continued From page 1	F 880		

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 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 38 residents. The sample included 3 residents. Based on observation, record review, and interview the facility failed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease 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 _____	C 10/30/2018

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 880	Continued From page 2	F 880		

infection, by not changing gloves during perineal care for 3 of 3 sampled residents. (#1, #2, #3)

Findings included:

- Resident #1's quarterly (MDS) Minimum Data Set assessment, dated 7/10/18, recorded the resident had severely impaired cognition with short and long-term memory problems. The MDS recorded the resident was totally dependent on 2 staff assistance for bed mobility, locomotion on and off the unit, dressing, toilet use, personal hygiene, bathing, required extensive assistance of 2 staff for transfers, and extensive assistance of 1 staff for eating. The MDS recorded the resident was frequently incontinent of bowel and bladder, and was not on a bowel or bladder toileting program.

The October, annual MDS was in progress and not completed yet.

The 10/23/17 (ADLs) Activities of Daily Living (CAA) Care Area Assessment did not trigger, and the Urinary Incontinence CAA was not completed.

The 7/20/18 ADL care plan recorded the resident had an ADL self-care performance deficit related to a diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), and required extensive assistance of one staff for toileting.

The 7/20/18 incontinence care plan recorded the resident had mixed bladder incontinence related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 880	Continued From page 3	F 880		

to dementia (progressive mental disorder characterized by failing memory, confusion). The care plan directed staff the resident was to wear an incontinent brief at all times, to clean the resident's peri-area with each incontinent episode, encourage fluids during the day, monitor, document, and report as needed, any possible causes of incontinence.

The 5/24/18 at 9:40 AM, nurse's note recorded at 7:45 AM the resident returned from the hospital emergency room with an order to start Bactrim DS (antibiotic) 1 tablet, (PO) by mouth, (BID) twice a day for 5 days for a diagnosis of a (UTI) Urinary Tract Infection, continue the same medications and diet, and at 9:40 AM, staff administered the first dose of Bactrim DS to the resident.

The 5/24/18 physician's order directed staff to administer Bactrim DS 800-160 (mg) milligrams BID for 5 days, to the resident, for a UTI.

The 9/11/18 at 5:54 AM, nurse's note recorded the facility was notified by the hospital that the resident was returning to the facility on Bactrim DS for a UTI.

The 9/11/18 Physician's order directed staff to administer Bactrim DS 800-160 mg BID for 7 days, to the resident, for a UTI.

On 10/29/18 at 12:55 PM, observation revealed Nurse Aides N and M assisted the resident to

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 _____	C 10/30/2018

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 880	Continued From page 4	F 880		

his/her room in his/her wheelchair, and applied gloves. Observation revealed Nurse Aide N moved the resident's feet and placed the sit to stand lift sling around the resident, raised the resident up in the lift and transferred him/her to the bathroom. Nurse Aide M pulled down the resident's pants and incontinent brief, checked the brief, and it was dry. Nurse Aide N, wearing the same gloves, went to the resident's bed, pulled an incontinent pad out from under the blankets and placed it on top of the bed. Nurse Aide M, wearing the same gloves, came out of the bathroom, picked up a bottle of cleansing cream, then both aides went back into the bathroom. Nurse Aide M, wearing the same soiled gloves, adjusted his/her clothing, touched the lift, wiped his/her nose with the back of his/her right hand, obtained wet wipes and placed cleansing cream on the wipes. Observation revealed Nurse Aide N raised the resident up in the lift while Nurse Aide M, still wearing the same soiled gloves, wiped the resident's peri area once, from front to back, pulled up the resident's incontinent brief and pants, then removed his/her gloves. Observation revealed Nurse Aide N, wearing the same soiled gloves, transferred the resident, in the lift, to his/her bed, removed his/her gloves, assisted the resident to lay down, lowered the bed, covered the resident with a sheet, and gave him/her the bell to ring for assistance.

On 10/30/18 at 8:41 AM, Nurse Aides N and O assisted the resident to his/her room in his/her wheelchair, along with the sit to stand lift. Nurse Aide N applied gloves, then removed the foot pedals from the resident's wheelchair, placed the lift sling around the resident and attached them to

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 _____	C 10/30/2018

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 880	Continued From page 5	F 880		

the lift. Nurse Aide O applied gloves, and both aides transferred the resident to the bathroom. Observation revealed Nurse Aide O, wearing the same gloves, removed the soiled incontinent brief, while Nurse Aide N lowered the resident to the toilet, moved the resident's wheelchair, pillows, and the resident's recliner. Nurse Aide N then raised the resident up off the toilet using the lift, and Nurse Aide O, wearing the same soiled gloves, performed peri care with wet wipes, applied barrier cream, removed his/her gloves, and pulled up the resident's clean incontinent brief and pants. Nurse Aide N controlled the lift, then removed his/her gloves. Observation revealed the resident was transferred to his/her recliner, repositioned, feet elevated on the foot rest, and given his/her call bell.

On 10/29/18 at 1:10 PM, Nurse Aide M stated he/she should have changed his/her gloves whenever he/she went from soiled items to clean items.
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On 10/29/18 at 1:10 PM, Nurse Aide N stated he/she should have changed his/her gloves more often, especially after touching soiled items.

On 10/30/18 at 4:06 PM, Administrative Nurse D stated he/she expected staff to change their gloves between touching a soiled brief and a clean brief, doing anything that was soiled to clean. Staff need to change their gloves more often. Administrative Nurse D stated staff not changing their gloves could possibly be a cause of the UTIs the facility was dealing with.

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 _____	C 10/30/2018

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 880	Continued From page 6	F 880		

The facility's undated Infection Control policy documented staff were to follow hand hygiene procedures during direct resident contact. All staff are responsible for following hand hygiene protocols of the facility and be able to demonstrate competency in hand hygiene at least annually.

The facility failed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection by not changing gloves during perineal cares and continued to provide care to Resident #1, placing the resident at risk for continued UTIs.

- Resident #2's admission (MDS) Minimum Data Set assessment, dated 10/1/18, recorded the resident had a (BIMS) Brief Interview for Mental Status score of 11, indicating moderately impaired cognition, mild depression, with no behaviors. The MDS recorded the resident was totally dependent on 2 staff assistance for bathing, required extensive assistance of 2 staff for bed mobility, transfers, locomotion on the unit, dressing, toilet use, personal hygiene, extensive assistance of 1 staff for locomotion off the unit, and independent with setup help only for eating. The MDS recorded the resident was frequently incontinent of bladder and occasionally incontinent of bowel.

The 10/1/18 Urinary Incontinence (CAA) Care Area Assessment recorded the resident had a diagnosis of overactive bladder and received medication. The CAA recorded the resident

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 _____	C 10/30/2018

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 880	Continued From page 7	F 880		

struggled with stress urinary incontinence, wore incontinent products for protection, and required extensive staff assistance with toileting.

The 10/8/18 (ADLs) Activities of Daily living care plan recorded the resident had a self-care performance deficit and required extensive assistance of 2 staff for toileting. The care plan recorded the resident had a history of urinary tract infections and directed staff to encourage adequate fluid intake, give antibiotic therapy as ordered, monitor and document for side effects and effectiveness, monitor daily vital signs, notify the physician of significant abnormalities, monitor, document, and report, as needed, signs and symptoms of a urinary tract infection. The care plan further directed staff to assist the resident with peri care twice a day, clean the resident's peri area well after each bowel movement, in order to help prevent bacteria in the urinary tract, provide cranberry juice or prune juice to help keep urine acidic, void at first urge, and wear clean underwear daily.

The 10/8/18 incontinence care plan recorded the resident had mixed bladder incontinence, used disposable incontinent briefs for protection, and directed to staff to change the brief as needed, clean the resident's peri-area with each incontinent episode, encourage fluids during the day, and monitor and document for signs and symptoms of a urinary tract infection and possible causes of incontinence.

The 10/17/18 at 1:01 AM, nurse's note recorded the resident was to received Keflex (antibiotic)

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 _____	C 10/30/2018

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 880	Continued From page 8	F 880		

500 (mg) milligrams, (TID) three times a day for UTI.

The 10/17/18 Physician order directed staff to administer Keflex 500 mg, TID, for 10 days, to the resident, for a UTI.

On 10/29/18 at 12:43 PM, observation revealed Nurse Aides M and N assisted the resident to his/her room in his/her wheelchair, and prepared to transfer the resident with the sit to stand lift. Observation revealed both aides applied gloves, then Nurse Aide N touched the resident's feet and legs and removed the wheelchair pedals. Nurse Aide M raised the resident up with the lift, and transferred him/her to the bathroom. Observation revealed both aides pulled down resident's pants and soiled incontinent brief, Nurse Aide M wiped his/her forehead, adjusted his/her hair and clothes, and touched the back/top of the resident's recliner. After the resident was finished voiding, Nurse Aide N raised the resident off of the toilet, Nurse Aide M, still wearing the same soiled gloves, obtained a wet wipe with cleansing cream on it, wiped the front peri area once, then continued to the rectum, and pulled up the resident's clean incontinent brief and pants. Observation revealed the aides transferred the resident out of the bathroom, using the lift to his/her recliner. Nurse Aide M then removed the glove on his/her left hand, and continued to assist the resident to his/her recliner. Observation revealed Nurse Aides M and N removed their gloves after the resident was in the recliner, they then repositioned the resident in the recliner, elevated his/her feet, gave the resident his/her call light and covered him/her with a blanket.

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 _____	C 10/30/2018

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 880	Continued From page 9	F 880		

On 10/30/18 at 9:13 AM, Nurse Aides N and O assisted the resident to his/her room in his/her wheelchair, along with the sit to stand lift. Observation revealed both aides applied gloves, Nurse Aide N removed the wheelchair pedals, placed the resident's feet on the lift pedals, and placed the lift sling around the resident. Both aides attached the sling to the lift and transferred the resident to the bathroom. Nurse Aide O lowered the resident's pants and incontinent brief, and the resident was dry. Nurse Aide N lowered the resident onto the toilet, after resident finished voiding, Nurse Aide N raised the resident up in the lift while Nurse Aide O, still wearing the same gloves, used a wet wipe to cleanse the resident's peri area from front to back, removed his/her gloves, and placed a clean incontinent brief on the resident, with assistance from Nurse Aide N, who was still wearing the same gloves. After dressing the resident, the aides transferred the resident to his/her recliner, elevated his/her feet on the foot rest, and gave the call light to the resident.

On 10/29/18 at 1:10 PM, Nurse Aide M stated he/she should have changed his/her gloves whenever going from soiled items to clean items.

On 10/30/18 at 9:23 AM, Nurse Aide O stated he/she was not sure if he/she performed proper peri care, but if staff were required to change their gloves after each dirty to clean item, the facility was going to need a lot more gloves.

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 _____	C 10/30/2018

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 880	Continued From page 10	F 880		

On 10/30/18 at 4:06 PM, Administrative Nurse D stated he/she expected staff to change their gloves between touching a soiled brief and a clean brief, doing anything that was soiled to clean. Staff need to change their gloves more often. Administrative Nurse D stated staff not changing their gloves could possibly be a cause of the UTIs the facility was dealing with.

The facility's undated Infection Control policy documented staff were to follow hand hygiene procedures during direct resident contact. All staff are responsible for following hand hygiene protocols of the facility and be able to demonstrate competency in hand hygiene at least annually.

The facility failed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection by not changing gloves during perineal cares and continued to provide care to Resident #2, placing the resident at risk for continued UTIs.

- Resident #3's quarterly (MDS) Minimum Data Set assessment, dated 7/3/18, recorded the resident had moderately impaired cognition with short and long term memory problems, and wandering. The MDS recorded the resident was totally dependent on 2 staff assistance for bathing, required extensive assistance of 2 staff for bed mobility, transfers, walking in the room and corridor, dressing, toilet use, personal hygiene, extensive assist of 1 staff for locomotion on and off the unit, and independent with setup help only for eating. The MDS recorded the

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 _____	C 10/30/2018

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 880	Continued From page 11	F 880		

resident was occasionally incontinent of bowel and bladder.

The annual MDS, dated 10/3/18, was the same as the 7/3/18 assessment except; he/she had fluctuating inattention and disorganized thinking, hallucinations, and rejection of care behaviors, but no wandering. The MDS recorded the resident was totally dependent on 1 staff for bathing, required extensive assistance of 2 staff for locomotion on the unit, and was frequently incontinent of bladder.

The 10/3/18 (ADLs) Activities of Daily Living (CAA) Care Area Assessment recorded staff provided extensive assist with most ADLs due to a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The Urinary Incontinence CAA recorded the resident was at risk for stress urinary incontinence and wore incontinent products for protection.

The 7/10/18 ADL care plan recorded the resident had a self-care performance deficit related to confusion, dementia, and impaired balance. The care plan recorded the resident required extensive assistance of one staff, and directed staff to toilet the resident every evening prior to bedtime.

The 7/10/18 care plan recorded the resident had mixed bladder incontinence and used disposable incontinent briefs. The care plan recorded the resident preferred to use the toilet at all times with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNSET HOME INC	620 SECOND AVENUE CONCORDIA, KS 66901

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F 880	Continued From page 12	F 880		

assistance, and directed staff to change the incontinent brief as needed, clean the resident's peri-area with each incontinence episode, and monitor and document for signs and symptoms of a (UTI) Urinary Tract Infection.

The 5/11/18 physician's order directed staff to administer Cipro 500 mg, (BID) twice a day, for a UTI until 5/21/18, order discontinued on 5/14/18.

The 5/12/18 at 6:44 AM, nurse's note recorded the facility received an order for Cipro (antibiotic) for the resident on 5/11/18 for a UTI, and had no signs or symptoms of any adverse side effects from the medication.

The 5/14/18 at 11:35 AM, nurse's note recorded the facility received lab results from the 5/10/18 urinalysis with new orders to stop the Cipro and start Cefdinir (antibiotic) 300 (mg) milligrams (BID) twice a day, for 7 days.

The 5/14/18 physician's order directed staff to administer Cefdinir 300 mg, BID, for 7 days for a UTI.

The 7/12/18 at 7:59 PM, nurse's note recorded the facility received orders to start Bactrim DS BID for 5 days after the urine specimen results today. The note documented staff administered 2 tablets from the emergency kit in order to begin the treatment tonight, and faxed an order to the pharmacy.

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 _____	C 10/30/2018

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 880	Continued From page 13	F 880		

The 7/16/18 at 10:59 PM, nurse's note recorded that was the last day of the antibiotic due to the resident having an allergy to the medication.

The 7/18/18 at 5:16 PM, nurse's note recorded the facility received orders from the resident's physician to start Levaquin 250 mg daily for 7 days for a diagnosis of UTI.

The 7/19/18 physician's order directed staff to administer Levaquin 250 mg, daily for 7 days for a UTI.

The 8/14/18 at 5:52 PM, nurse's note recorded the facility received the urinalysis results with orders to start Levaquin 250 mg BID for 7 days for a UTI.

The 8/14/18 physician's order directed staff to administer Levaquin 250 mg, daily, for 7 days for a UTI.

The 10/9/18 at 11:43 AM, nurse's note recorded the facility received urinalysis results with orders to start Keflex 500 mg (TID) three times a day for 7 days for a UTI.

On 10/29/18 at 12:29 PM, observation revealed Nurse Aide M assisted the resident to his/her room, applied gloves and propelled the resident to the bathroom in his/her wheelchair. Observation revealed the resident grabbed a hold

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 _____	C 10/30/2018

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 880	Continued From page 14	F 880		

of the grab bar, was assisted to stand by Nurse Aide M, turned and sat down on the toilet. Nurse Aide M pulled down the resident's jeans and incontinent brief, and the brief was wet. Nurse Aide M removed the incontinent brief, and wearing the same soiled gloves, placed a clean incontinent brief on the resident. Observation revealed Nurse Aide M obtained the resident's walker and brought it to the resident. Wearing the same soiled gloves, Nurse Aide M obtained wet wipes and applied cleansing cream. Observation revealed the resident started to cough up a large amount of sputum, acted as though he/she was going to spit it on the floor, so Nurse Aide M gave the resident a tissue, and grabbed the trash can, so the resident could spit in it, then threw the tissue with sputum in it, in the trash can. Observation revealed Nurse Aide M, still wearing the same soiled gloves, used the wet wipe with cleansing cream on it, and wiped the resident from front to back, but did not perform frontal peri care. Wearing the same soiled gloves, Nurse Aide M pulled up the resident's clean incontinent brief and jeans, assisted the resident to ambulate with his/her walker to his/her recliner, elevated the resident's feet on the foot rest of the recliner, gave him/her the call light, attached it to his/her shirt, then removed his/her soiled gloves. Nurse Aide M covered the resident with a blanket, emptied the trash can and left the room.

On 10/30/18 at 8:51 AM, observation revealed Nurse Aides N and O assisted the resident to his/her room in his/her wheelchair. Observation revealed both aides applied gloves, Nurse Aide O shut the door, and Nurse Aide N moved the resident's walker and placed a gait belt on the resident. Observation revealed both aides locked

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F 880	Continued From page 15	F 880		

the wheelchair brakes, assisted the resident to stand and ambulated to the bathroom. Nurse Aide O pulled down the resident's pants and incontinent brief, and the resident was dry. After the resident voided on the toilet, Nurse Aide O, wearing the same soiled gloves, obtained wet wipes, both aides assisted the resident to stand with his/her walker, Nurse Aide O wiped the resident's front peri area and rectum, and applied protective ointment, both aides removed their gloves, and pulled up the resident's pants. Observation revealed the aides assisted the resident to ambulate to his/her recliner, elevated his/her feet on the foot rest on the recliner, covered him/her with a blanket, and provided the call light.

On 10/29/18 at 1:10 PM, Nurse Aide M stated he/she should have changed his/her gloves whenever he/she went from a soiled item to a clean item, and when he/she went out of the bathroom and came back in.

On 10/29/18 at 1:10 PM, Nurse Aide N stated he/she should have changed his/her gloves more often, especially after touching soiled items.

On 10/30/18 at 4:06 PM, Administrative Nurse D stated he/she expected staff to change their gloves between touching a soiled brief and a clean brief, doing anything that was soiled to clean. Staff need to change their gloves more often. Administrative Nurse D stated staff not changing their gloves could possibly be a cause of the UTIs the facility was dealing with.

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F 880	Continued From page 16 The facility's undated Infection Control policy documented staff were to follow hand hygiene procedures during direct resident contact. All staff are responsible for following hand hygiene protocols of the facility and be able to demonstrate competency in hand hygiene at least annually. The facility failed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection by not changing gloves during perineal cares and continued to provide care to Resident #3, placing the resident at risk for continued UTIs.	F 880		