STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 citations represent the findings of a Health Resurvey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

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F 580	Continued From page 1	F 580		

(e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 36 residents with 13 in the sample. Based on observation, interview, and record review the facility failed to notify the physician, as ordered, when Resident (R) 24's blood sugars were higher than 450 milligrams per deciliter (mg/dl).

Findings included:

- Review of R24's 01/06/20 signed "Physician Orders" revealed the following diagnoses: type 2 diabetes mellitus without complications (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin).

Review of the "Care Plan" dated 04/05/2012 revealed the staff were to obtain blood sugars as ordered by the physician, and monitor/document for side effects and effectiveness.

Review of the 01/06/20 "Physician's orders" instructed staff to call the physician for blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 580	Continued From page 2	F 580		

sugars above 450 mg/dl.

Review of the record revealed blood sugar levels from 06/01/19 to 01/08/20 with no physician notification when R24's blood sugar was higher than 450 mg/dl on the following dates:
06/06/19 at 07:47 PM revealed a blood sugar of 476 mg/dl
06/17/19 at 11:56 AM revealed a blood sugar of 489 mg/dl
06/18/2019 at 03:00 PM revealed a blood sugar of 452 mg/dl
12/26/19 at 11:51 AM revealed a blood sugar of 58 mg/dl
12/26/19 at 10:05 AM revealed a blood sugar of 483 mg/dl

Interview on 01/08/2020 at 08:35AM with Certified Mediation Aide (CMA) B revealed the blood sugars were completed by the nurses on the floor.

Interview on 01/08/2020 at 02:02 PM with Licensed Nurse (LN) A revealed if the blood sugars were above 450 mg/dl, the nurses were to notify the physician. and if the blood sugar was low the nurses contacted the physician.

Interview on 01/09/2020 at 10:19 AM with Administrative Nurse C revealed any time the residents blood sugar were over 400 mg/dl the blood sugars were rechecked after administration of insulin as ordered and if still above 400 mg/dl staff notified the physician.

Review of the policy regarding "Diabetic Management/Insulin" with an effective date of 06/28/17 revealed each resident should have physician orderd parameter for blood glucose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 580	Continued From page 3 levels requiring physician notification. The facility failed to notify the physician of blood sugars above 450 mg/dl as per physician orders for R24.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: The facility census totaled 36 residents with 13	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 657	Continued From page 4	F 657		

included in the sample. Based on observation, interview, and record review the facility failed to revise the care plan to include monitoring and use of insulin for one of 13 sampled residents as related to the diagnosis of diabetes mellitus. Resident (R) 30.

Findings included:

- Signed "Physician's Orders" dated (12/19) identified R30 with multiple medical diagnoses, including type 2 diabetes mellitus with hyperglycemia (disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine).

Review of the significant change in status "Minimum Data Set" (MDS) dated 12/11/19 revealed a "Brief Interview for Mental Status" (BIMS) score of 13 indicating intact cognition. The resident received insulin injections.

The "Care Area Assessment" (CAA) for Nutrition dated 12/11/19 noted R30's diagnosis of diabetes and did not mention blood glucose monitoring or use of insulin.

The 10/31/18 "Care Plan" noted the presence of a potential for a nutritional problem related to the diagnosis of diabetes mellitus. The care plan included multiple interventions related to the diagnosis of diabetes, including use of a sugar free dietary supplement twice daily. The care plan lacked interventions related to blood glucose monitoring and/or use of insulin.

A "Physician Order" dated 03/02/19 directed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 657	Continued From page 5 to complete "accuchecks" (blood glucose/blood sugar monitoring test) four times daily. A 12/03/19 "Physician Order" directed staff to administer insulin for blood glucose levels greater than 400 milligrams per deciliter (mg/dl). A 12/13/19 "Physician Order" directed staff to administer insulin injection to R30 three times daily with meals. During an observation on 01/07/20 at 11:44 AM, Licensed Nurse (LN) A performed blood glucose monitoring for R30 and obtained a result of 409 mg/dl (normal blood glucose levels range from 70-125 mg/dl). LN A then administered insulin via an injection into R30's lower right abdomen. During an interview on 01/7/20 at 11:30 AM, LN A confirmed R30 often experienced high blood glucose levels which required as needed (PRN) does of insulin. During an interview on 01/08/20 at 01:25 PM Administrative Nurse F acknowledged the current care plan lacked interventions related to blood glucose monitoring and use of insulin. The facility did not provide a policy for Care Plans as requested on 01/13/20 at 07:50 AM. The facility failed to review/revise the care plan to include blood glucose monitoring and use of insulin for R30.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 661	Continued From page 6	F 661		

When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.
(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.
(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).
(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 36 residents with 13 in the sample, which included Resident (R) 36 for discharge review. Based on interview and record review the facility failed to document a recapitulation of R36's stay upon discharge.

Findings included:

- Review of R36's "Physician Order Sheet" dated 10/07/19 revealed the following diagnoses:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 661	Continued From page 7	F 661		

malignant (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) neoplasm of bladder unspecified (tumor) and malignant (the tendency of a medical condition, especially tumors, to become progressively worse, most familiar as a characteristic of cancer) neoplasm of left bronchus or lung (tumor).

The five-day Medicare "Minimum Date Set" (MDS) dated 10/11/19 revealed a brief interview for mental status (BIMS) score of 13, indicating intact cognition. The resident required one-person assistance with activities of daily living.

The "Care Plan" dated 10/07/19 revealed R36 wished to return to her home after completing skilled stay.

The "Nurse's Note" dated 10/14/19 at 01:15 PM revealed R36 discharged from the facility.

Review of the resident record lacked evidence of a discharge summary recapitulation for R36's discharge on 10/14/19.

Interview on 01/08/20 at 01:08 PM with Social Service Staff (SS) L revealed the discharge planning began on the day the resident came to the facility and typically the nursing staff conducted the resident education on medications, treatments, and any follow up appointments with the physician. SS L said the recapitulation of stay did not get done.

Review of the policy dated 01/08/20 with an effective date of 01/09/20 revealed the facility provided a recapitulation of resident's stay which included diagnoses, course of illness/treatment,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 661	Continued From page 8 pertinent labs, radiology, and consultation results at the time of discharge. The facility failed to document a discharge summary recapitulation of R36's stay at the facility upon discharge, as required.	F 661		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility census totaled 36 residents with 13 included in the sample. The sample included review of oxygen/respiratory services for one Resident (R) 25. Based on observation, interview, and record review the facility failed to provide oxygen therapy in a sanitary manner (labeling of oxygen tubing to include the change date) for R25 who utilized supplemental oxygen. Findings included: - Review of Resident (R) 25's signed physician orders dated 11/19 revealed the following diagnoses: chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and malignant neoplasm of esophagus (cancer of	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 695	Continued From page 9	F 695		

the esophagus).

Review of the significant change in status "Minimum Data Set" (MDS) dated 09/11/19 revealed a "Brief Interview for Mental Status" (BIMS) score of 15 indicating intact cognition. The resident was short of breath all times and dependent on oxygen (O2) to breath. The resident had a terminal diagnosis.

Review of the quarterly "MDS" dated 11/27/19 revealed no changes in cognition. The resident had a terminal diagnosis and received O2 therapy and chemotherapy.

The 04/20/16 "Care Plan" noted R25's use of continuous oxygen at 3 liters per minute. The care plan lacked guidance related to the desired frequency staff should change the oxygen tubing. The care plan also lacked guidance related to labeling of the oxygen tubing.

Physician orders dated 01/01/18 directed staff to wash the oxygen (O2) concentrator filter, change oxygen tubing and wipe the machine with an antiseptic cloth every Monday.

Physician orders dated 08/19/18 directed staff to provide R25 with continuous (O2) at 3 liters per minute per nasal cannula for COPD.

On 01/06/2020 at 03:18 PM observation revealed R25 laid in bed with O2 infusing per nasal cannula at 3 liters per minute as ordered by the physician. The oxygen tubing lacked a label to note the date staff last changed the tubing.

On 01/07/2020 at 07:25 AM, R25 sat in a wheelchair pushed by transportation staff. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 10 resident had O2 running per portable O2 tank and nasal cannula. Again, the oxygen tubing lacked a label to note the date staff last changed the tubing. During an interview on 01/07/2020 at 09:29 AM Licensed Nurse (LN) I reported the night shift nurses changed the O2 tubing and signed for it on the "Medication Administration Record" (MAR). She stated the nurses used to write the date on the tubing, but it would get rubbed off, so they stopped labeling the tubing itself. The 03/2006 facility policy, "Oxygen Therapy" directed staff to change oxygen tubing weekly an as needed (PRN), mark tubing with tape and note the date and initials of the person changing the tubing. The policy directed staff to then document the tubing change on the MAR. The facility failed to provide oxygen therapy to R25 in a sanitary manner when they failed to label the oxygen tubing with the "change date."	F 695		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: The facility census totaled 33 residents with 13 included in the sample. Based on observation, interview, and record review the facility failed to monitor behaviors related to dementia for three of 13 sampled residents. (Residents (R)27, R16,	F 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 11 and R1)	F 744		

Findings included:

- Review of R1's signed "Physician Orders" dated 11/22/2019 revealed the following diagnosis: Alzheimer's disease with late onset (progressive mental deterioration characterized by confusion and memory failure).

Review of the 09/18/19 "Minimum Data Set" (MDS) revealed a brief interview for mental status (BIMS) score of one, which indicated severely impaired cognition. According to the MDS, R1 exhibited behaviors of hitting, kicking, pushing, scratching, and/or grabbing others one to three days during the seven-day observation period.

Review of the annual 12/18/19 "MDS" revealed a continued BIMS of one, which indicated severely impaired cognition. According to the MDS, R1 did not exhibit any behaviors.

The 12/18/19 "Care Area Assessment" (CAA) for cognition noted R1's short- and long-term memory problems as well as communication issues in which R1 rarely understood others. The Mood "CAA" described R1's tendency to become upset during care but was easily redirected with candy or food and directed staff to observe and assess for changes in mood and report those concerns to the physician.

The 09//25/19 "Care Plan" noted R1's impaired cognitive function and impaired thought processes. The "Care Plan" directed staff to monitor/document/report to physician any changes in cognitive function, specifically changes in decision making ability.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 744	Continued From page 12	F 744		

Review of the "Nurses Notes" revealed lack of documentation of follow-up charting for behavior monitoring after the following "Certified Nurse Aide" (CNA) task charting on the electronic charting system:
01/02/20 at 08:35 PM - R1 observed kicking/hitting noted
01/06/20 at 05:47 AM - R1 rejection of care noted

During an observation on 01/06/20, R1 ambulated in the hallway with CNA J and did not exhibit any negative behaviors during the observation.

Interview on 01/08/20 at 08:35 AM with Certified Medication Aide (CMA) B regarding behavior monitoring revealed the staff observed the resident for any out of the normal behaviors which were in our task in the electronic charting system. CMA B said the staff charted and notified the nurses on the floor of what behaviors the staff observed, and the nurses charted more in depth on the resident for rejection of care, kicking hitting, grabbing at others.

Interview on 01/08/20 at 08:30 AM with Licensed Nurse (LN) A regarding behavior monitoring revealed the CNA's monitored the behaviors in their task on the electronic charting system if behaviors were observed and documented in the task. LN A said the CNAs then filled out a form for the nurse. The nurse then assessed the resident and charted the behaviors in the resident's chart.

Interview on 01/08/20 at 08:36 AM with Administrative Nurse C revealed she expected the CNAs to notify the charge nurse of any behaviors out of the normal for resident so that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 13	F 744		

the LNs were able to chart on the residents.

Interview on 01/13/20 at 11:00 AM with Consultant Pharmacist K revealed the resident's charts were checked for abnormal involuntary movements (AIMS) test and nurses notes for any behaviors. If the staff charted the behaviors elsewhere, Consultant Pharmacist K said he/she did not have access to it.

Review of policy dated 01/10/19 revealed the charge nurse assessed the resident for behaviors and any environmental triggers would be documented in the nurses progress notes.

The facility failed to monitor behaviors for R1 - Review of R27's signed "Physician Orders" revealed the following diagnoses: unspecified dementia without behavioral disturbance (progressive mental disorder characterized by failing memory), confusion, alcohol dependence, and anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

Review of the significant change in status "Minimum Data Set" (MDS) dated 03/20/19 revealed the resident had severe cognitive impairment. The resident had no behaviors. The resident required extensive assistance of one staff with ambulation, mobility, toileting and dressing. The resident was steady with ambulation and transfers. The resident received pain medications on schedule, had no falls and received opioid pain medications and received hospice services for a terminal diagnosis.

Review of the quarterly "MDS" dated 12/04/19 revealed the resident had no change in cognition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 14	F 744		

The resident had behaviors of physical behaviors towards others, rejection of care, and wandering on ont to three days during the seven-day observation period. The resident had a decline in ADLs requiring extensive assistance of two staff for transfers, dressing and toilet use and limited assistance of one for ambulation. The resident required extensive assistance for locomotion on and off the unit and total assistance with bathing. The resident had a terminal diagnosis and was unsteady with ambulation having two or more non-injury falls. The resident received an antipsychotic, antianxiety, diuretic, and opioid pain medication and received hospice for end of life issues.

Review of the "Care Area Assessment" (CAA) dated 03/09/19 regarding cognitive loss/dementia revealed the resident received hospice services amd required staff to continue to remind/cue, offer suggestions, and assistance as needed with the above difficulties. Staff to observe/assess for changes in cognitive function and report to the physician as needed/warranted. The staff were also to observe/assess for interventions needed to assist with cognitive function and implement and/or notify physician as needed and to observe/assess for any complications and report any/all concerns to physician as needed/warranted.

Review of the "Care Plan" dated 01/29/16 revealed the resident was resistive to care at times related to dementia and has a history of sleeping problems (difficulty falling asleep). The approaches included to allow the resident to make decisions about treatment regime, to provide sense of control. When resident refused care, the staff were to remind him that his family

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 15	F 744		

requested Activities of daily living (ADLs) to be completed. If the resident continued to resist all care, the staff were to notify the charge nurse of the behavior. The staff were to educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care and tell the resident what could happen even though he may not comprehend.

The "Care Plan" further revealed the resident has impaired cognitive function related to a diagnosis of senile dementia (initiated 09/12/14) and included the following approaches: The resident could become frustrated when he was unable to state what was on his mind or if he was asked too many questions dealing with his feelings. The staff were to redirect by changing the subject and if the staff saw the resident becoming agitated or frustrated (initiated 11/02/15).

Review of the 11/24/19 "Physician Order" revealed an order for Seroquel 50 milligrams (mg), one time day for anxiety disorder.

Review of the Certified Nursing Assistant (CNA) behavior documentation for 30 days (12/07/19-01/08/20) revealed the resident had 16 "behaviors", including:
Two incidents of kicking, hitting on 01/05/20 and 01/07/20
One incident of threatening behavior on 01/07/20
Three incidents of wandering on 12/10/19, 12/11/19, and 12/26/19
Ten incidents of rejection of care on 12/10/19, 12/11/19, 12/13/19, 12/16/19, 12/21/19, 12/23/19, 1/2/2020, 1/3/2020, 1/5/2020, and 1/7/2020.

Of the 16 behaviors documented by CNAs, a Licensed Nurse assessed the behaviors, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 16	F 744		

documented follow up only one time (12/08/2019 at 04:19AM). According to that note, the resident became combative and was swinging at staff with closed fists when cares were attempted. The 15 other behavioral incidents documented by CNAs lacked evidence of licensed nurse awareness, assessment, and follow up.

Observation on 01/06/2020 at 09:00AM revealed the resident ambulated around his room. The resident was wringing his hands and appeared anxious. The resident had a wandergard on his wrist. The resident lacked the ability to answer simple questions and became increasingly anxious.

During an interview on 01/06/20 at 11:10 AM a family member of R27 reported the resident had severe Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) and kept to himself a lot. Lately he had been coming to the TV area and seemed like he was watching the programs. He was calm most of time though would have periods where he became anxious. In the evening he would wander around but not really during the day so much. They keep a wandergard (electronic bracelet to alert staff if resident would try to leave by an alarmed door) on him as a precaution though he has not tried to leave.

During an interview on 01/08/20 at 02:30 PM Certified Nursing Assistant (CNA) E reported the resident tended to wander in the evenings. He did not exit seek, just walked in the halls. The resident could also get pushy with staff and attempt to hit them with personal cares. She reported staff charted the resident's behaviors in their charting and let the nurse know of any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 17	F 744		

behaviors. She did not know what the nurse did with that information.

During an interview on 01/08/20 at 08:30 AM Licensed Nurse (LN) A revealed the CNA's monitored behaviors in their task list on the facility's electronic health record program and, if they observed a behavior, they documented in the task list and also filled out a form for the nurse to review. The nurse then assessed the resident and charted the behaviors in the clinical record.

During an interview on 01/08/2020 at 0836 AM, Administrative Nurse C revealed the location of the behavior monitoring for specific behaviors of residents in the CNA task list in the electronic health record program. Adminsitrative Nurse C reported she expected the CNAs to notify the charge nurse of any behaviors outside of normal behaviors, and the nurses would then chart on those behaviors. Administrative Nurse C also reported "psychiatric patients" required charting for 72 hours following a change in behaviors.

Review of policy dated 01/10/19 revealed the charge nurse assessed the resident for behaviors and any environmental triggers would be documented in the nurses progress notes.

The facility failed to monitor behaviors related to dementia for R27.

- Review of R17's signed "Physician Orders" dated 12/03/19 revealed the following diagnoses: multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), dementia with behavioral disturbance (progressive mental disorder characterized by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 18	F 744		

failing memory, confusion), and major depressive disorder, recurrent, moderate (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness).

Review of the annual "Minimum Data Set" (MDS) dated 08/07/19 revealed a "Brief Interview for Mental Status" (BIMS) score of eight which indicated moderate cognitive impairment. The resident had mild depression with physical and verbal behaviors. The resident required extensive assistance of two staff for daily care and was dependent on staff for assistance for transfers and mobility. The resident received pain medication on a scheduled basis and had occasional mild pain. Medications included antipsychotic, antianxiety, antidepressant, and opioid medications daily in the seven-day observation period.

Review of the quarterly "MDS" dated 11/06/19 revealed no significant changes in status from previous assessment dated 08/07/19.

Review of the "Care Area Assessment" (CAA) dated 08/07/19 revealed:
Cognitive Loss/Dementia "CAA" revealed the resident required staff to continue to remind/cue, offer suggestions, and assist as needed.

Behavioral problems "CAA" revealed the resident became frustrated at times and cursed and yelled at others. The resident had MS, which causes her frustration and a diagnosis of dementia with behavioral disturbances and anxiety. Usually staff redirected the resident by giving the resident time and space and reproaching later. The resident required staff to observe/assess for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 19	F 744		

contributing factors to behaviors and intervene as needed/warranted. The staff were to observe/assess for interventions that decrease behaviors and implement and/or notify physician as needed/warranted and the staff also needed to observe/assess for changes in behaviors and report concerns to physician as needed/warranted.

Psychotropic drug use "CAA" revealed the resident was currently on depression, anxiety, and antipsychotic medication (Zyprexa) for dementia with behavioral disturbance. The resident required staff to observe/assess for contributing factors to behaviors and intervene as needed/warranted. The staff were to observe/assess for interventions that decreased behaviors and implement and/or notify the physician as needed/warranted and staff also needed to observe/assess for changes in behaviors and report concerns to the physician as needed/warranted.

Review of the 07/17/14 "Care Plan" revealed the resident had Dementia, which affects cognition and communication
and included the following approaches:
03/21/15: Two staff members were to assist the resident and noted one staff should not attempt the residents care due to her behaviors.
03/03/2017: The resident had mood/behavior problems due to depression/anxiety agitation/dementia with
behavioral disturbances and the potential to demonstrate verbally abusive behaviors related to anxiety and agitation.
The resident had the potential to demonstrate physical abuse by kicking out/hitting/swatting at staff. The staff were to attempt to calm the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 20	F 744		

resident's mood by changing the subject and if this did not work, ensure the resident was safe and come back later or request another staff intervene. If the resident exhibited symptoms of depression, the staff were to offer to visit 1:1 and allow her the opportunity to elaborate on her thoughts/feelings and report changes in mood or threats of self-harm to charge nurse.
11/21/18: The resident would scream and curse at staff and the staff were to redirect her as needed/reapproch later. The resident's mental health needs would be addressed by telehealth.

Review of the Certified Nurse Aide (CNA) task list for behavior monitoring within the previous 30 days (12/08/19- 01/07/20,) revealed the resident had behaviors a total of 18 times, including "grabbing" on eight occasions and "yelling" on 10 occasions.

Review of the nurse's "Progress Notes" for the same 30-day time period from 12/08/19-01/07/20 revealed licensed nurses documented about the resident's behaviors for only two of the 18 occurrences documented by CNAs.

Observation on 01/06/20 at 03:22 PM revealed the resident lay awake in her bed. The resident appeared agitated and yelled out although no other person was in her room. CNA H responded to her calls and provided support for the resident. The resident stopped yelling with staff in the room.

During an interview on 01/06/2020 at 03:28 PM CNA H reported the resident required extensive care for all cares. She became easily upset and yelled out. The resident would squeeze the staffs arm or hand but was not combative. She had left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 21	F 744		

sided weakness and could not hurt with her squeezes.

During an interview on 01/07/20 at 11:23 AM, Certified Medication Aide (CMA) D reported the resident did not exhibit combative behaviors often, but had "lots of yelling and cursing and gets very agitated."

During an interview at 08:35 AM on 01/08/20, CMA B reported staff monitored for "any behaviors out of the normal" and then documented those behaviors in the electronic record system under the CNA task list. Staff also notified the charge nurse of the behaviors and then the nurses charted in depth about the resident and the behaviors.

During an interview on 01/08/20 at 02:45 PM CMA E reported the resident's main behaviors were yelling and grabbing at staff. The resident was very impatient. If she wanted something she started yelling until the staff provided the care. The resident could easilty be redirected but liked someone with her.

During an interview on 01/08/20 at 08:30 AM Licensed Nurse (LN) A revealed the CNAs monitored resident behaviors and then documented them under the CNA task list in the electronic health record system. CNAs also "fill out a form" for the nurse. After nurses received the forms, they should assess the residents and chart on the behaviors in the clinical record.

During an interview on 01/08/20 at 08:36 AM Administrative Nurse C revealed the behavior monitoring was in the electronic record task list for the CNAs for specific behaviors that were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 744	Continued From page 22 beyond the normal behaviors seen. Administrative Nurse C expected CNA's to notify the charge nurse of any resident behaviors outside of normal for that resident, and then the nurses charted on the resident and the behaviors. Review of policy dated 01/10/19 revealed the charge nurse assessed the resident for behaviors and any environmental triggers would be documented in the nurses progress notes. The facility failed to monitor behaviors related to dementia, anxiety, and agitation for R16.	F 744		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 756	Continued From page 23	F 756		

(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility census totaled 36 residents with 13 in the sample. Based on observation, interview, and record review the facility failed to have a system in place to ensure reporting of drug irregularities (lack of blood sugar monitoring and/or staff response to blood sugar results outside of physician ordered parameters, and behavior monitoring) to the physician and director of nursing for three of five residents sampled for unnecessary medications. (Resident (R) 30, R27, and R17)

Findings included:

- Review of R27's 11/26/19 signed "Physician Orders" revealed the following diagnoses: unspecified dementia without behavioral disturbance (progressive mental disorder characterized by failing memory), confusion, alcohol dependence and, anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 756	Continued From page 24	F 756		

Review of the significant change in status "Minimum Data Set" (MDS) dated 03/20/19 revealed the resident had severe cognitive impairment and was unable to complete the BIMS. The resident had no behaviors noted.

Review of the quarterly "MDS" dated 12/04/19 revealed the resident had no change in cognition. The resident had behaviors noted as physical behaviors towards others, rejection of care, and wandering on one-to-three days during the seven-day observation period. The resident received antipsychotic, antianxiety, diuretic, and opioid pain medication and received hospice for end of life issues.

The 03/09/19 "Care Area Assessments" (CAAs) did not trigger the area of "Behaviors" for further investigation.

Review of the "Care Plan" dated 01/29/16 revealed the resident was resistive to care at times related to dementia and has a history of sleeping problems (difficulty falling asleep). The approaches included to allow the resident to make decisions about treatment regime, to provide sense of control. When resident refused care, the staff were to remind him that his family requested Activities of daily living (ADLs) to be completed. If the resident continued to resist all care, the staff were to notify the charge nurse of the behavior. The staff were to educate resident/family/caregivers of the possible outcome(s) of not complying with treatment or care and tell the resident what could happen even though he may not comprehend.

The "Care Plan" further revealed the resident has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 756	Continued From page 25	F 756		

impaired cognitive function related to a diagnosis of senile dementia (initiated 09/12/14) and included the following approaches: The resident could become frustrated when he was unable to state what was on his mind or if he was asked too many questions dealing with his feelings. The staff were to redirect by changing the subject and if the staff saw the resident becoming agitated or frustrated (initiated 11/02/15).

The 09/12/14 "Care Plan" further revealed the resident was taking some medications that could have some adverse effects and approches included the following:
12/05/19: Pharmacy review as ordered; See Medication list for current black box warnings
11/26/19: The resident received Seroquel for the diagnosis of dementia with psychosis. The medication
carried the following BLACK BOX WARNING: Seroquel-Not indicated for use in elderly patients with dementia-related psychosis because of increased risk of death from cardio vascular (CV) disease or infection.
12/06/19: The resident received Ativan to assist with anxiety. Ativan carries the following BLACK BOX WARNING: Opioids may cause slow or difficult breathing, sedation, and death. Avoid using together. If use together is necessary, limit dosage and duration of each drug to the minimum necessary for desired effect.

Review of the "Physician Orders" dated 11/24/19 included an order for Seroquel, an antipsychotic medication, 50 milligrams (mg) daily for an anxiety disorder.

On 11/26/2019 at 03:56 PM Consultant Pharmacist K identified a drug irregularity related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 756	Continued From page 26	F 756		

to staff failure to complete an abnormal involuntary movement scale (AIMS) assessment related to administration of antipsychotic medication. The consultant pharmacist did not identify other drug irregularities.

On 12/23/19, Consultant Pharmacist K completed another monthly drug regimen review and identified no drug irregularities.

Review of Certified Nurse Aide (CNA) behavior documentation for the 30-day time period from 12/07/19 - 01/08/20 revealed R27 exhibited undesired behaviors 16 times. Of those 16 times, licensed nurses completed assessments of the behaviors and documented the follow up in the clinical record only one time, on 12/08/19.

Observation on 01/06/20 at 09:00 AM revealed R27 ambulated within his room. The resident appeared anxious and was observed wringing his hands. During this observation, R27 was unable to answer questions.

During an interview on 01/06/20 at 11:10 AM a family member reported the resident had severe Alzheimer's (progressive mental deterioration characterized by confusion and memory failure) and kept to himself a lot. Recently R27 watched programs on television (TV) in the TV area. He remained calm most of time although he would have times when he became anxious. In the evening he would wander around but not really during the day so much.

During an interview on 01/08/20 at 08:36 AM, Administrative Nurse C reported CNAs document specific behavior monitoring for residents in the task list section of the electronic health record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 756	Continued From page 27	F 756		

According to Administrative Staff C, she expected CNAs to notify the charge nurse of any behaviors that were abnormal for the residents. The charge nurse should then "chart" on the resident and the behaviors.

During an interview on 01/13/20 at 11:00 AM Consulting Pharmacist K reported she checked the residents AIMS test and nurses notes for any behaviors. According to Consulting Pharmacist K behaviors documented elsewhere in the clinical record are not available to her for review.

Review of the undated facility policy, "Consultant Pharmacist Services Provider" revealed the pharmacist will submit a written report and recommendations for each review. The policy directed the pharmacist to review the medication regimen monthly for each resident, utilizing federally-mandated standards of care in addition to other applicable standards and documenting findings in the resident's medical record.

The facility failed to have a system in place to ensure reporting of drug irregularities (lack of assessment/follow up by licensed nurses for behaviors identified by CNAs) to the physician and director of nursing for R27.

- Review of R17's signed "Physician Orders" dated 12/03/19 revealed the following diagnoses: multiple sclerosis (progressive disease of the nerve fibers of the brain and spinal cord), dementia with behavioral disturbance (progressive mental disorder characterized by failing memory, confusion), and major depressive disorder, recurrent, moderate (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 756	Continued From page 28	F 756		

and hopelessness).

Review of the annual "Minimum Data Set" (MDS) dated 08/07/19 revealed a "Brief Interview for Mental Status" (BIMS) score of eight indicating moderate cognitive impairment. The resident had mild depression with physical and verbal behaviors. Medications included antipsychotic, antianxiety, antidepressant, opioid medications daily in the seven-day observation period.

Review of the quarterly "MDS" dated 11/06/19 revealed no significant changes in status from previous assessment dated 08/07/19.

Review of the "Care Area Assessment" (CAA) dated 08/07/19 revealed:

Behavioral CAA: The resident became frustrated at times and cursed and yelled at others. The resident has MS, and this causes her frustration. resident has a diagnosis of dementia with behavioral disturbances and anxiety. Usually staff redirect by giving the resident time and space and reproaching later. The resident will require staff to observe/assess for contributing factors to behaviors and intervene as needed/warranted. Staff to observe/assess for interventions that decrease behaviors and implement and/or notify physician as needed/warranted. Staff will also need to observe/assess for changes in behaviors and report concerns to physician as needed/warranted.

Psychotropic drug use CAA: Resident is currently on Sertraline for depression, Ativan for anxiety and Zyprexa for dementia with behavioral disturbance. The resident will require staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 756	Continued From page 29	F 756		

observe/assess for contributing factors to behaviors and intervene as needed/warranted. Staff to observe/assess for interventions that decrease behaviors and implement and/or notify physician as needed/warranted. Staff will also need to observe/assess for changes in behaviors and report concerns to physicians needed/warranted.

The 07/17/14 "Care Plan" included multiple approaches related to management of resident behaviors, including directing staff to redirect when R17 cursed and screamed at staff. The care plan also noted R17's potential to demonstrate physical abuse by kicking, hitting, swatting at staff.

Consultant Pharmacist K completed a monthly drug regimen review on 11/26/19 which included a recommendation to continue use of an antipsychotic medication without attempts at dosage reduction due to the continued presence of targeted behaviors. The review lacked identification of other drug irregularities.

A monthly drug regimen review completed on 12/23/19 identified no drug irregularities.

Review of Certified Nurse Aide (CNA) behavior documentation for the 30-day time period from 12/08/19 - 01/07/20 revealed R17 exhibited undesired behaviors (grabbing and yelling) a total of 18 times. Of those 18 times, licensed nurses completed assessments of the behaviors and documented the follow up in the clinical record twice.

During an observation on 01/06/20 at 03:22 PM R17 lay awake in bed. The resident appeared

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 756	Continued From page 30	F 756		

agitated and cried out although there were no other people in her room. CNA H responded to R17's vocalizations and the resident then quieted down.

During an interview on 01/08/2020 at 0:836 AM, Administrative Nurse C reported CNAs document specific behavior monitoring for residents in the task list section of the electronic health record. According to Administrative Staff C she expected CNAs to notify the charge nurse of any behaviors that were abnormal for the residents. The charge nurse should then "chart" on the resident and the behaviors.

During an interview on 1/13/2020 at 11:00 AM Consulting Pharmacist K reported she checked the residents AIMS test and nurses notes for any behaviors. According to Consulting Pharmacist K, behaviors documented elsewhere in the clinical record are not available to her for review.

Review of the undated facility policy "Consultant Pharmacist Services Provider" revealed the pharmacist will submit a written report and recommendations for each review. The policy directed the pharmacist to review the medication regimen monthly for each resident, utilizing federally-mandated standards of care in addition to other applicable standards and documenting findings in the resident's medical record.

The facility failed to have a system in place to ensure reporting of drug irregularities (lack of assessment/follow up by licensed nurses for behaviors identified by CNAs) to the physician and director of nursing for R17.

- Review of R30's signed "Physician Orders"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 756	Continued From page 31	F 756		

dated 11/26/19 revealed the following diagnosis: type 2 diabetes mellitus with hyperglycemia (disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine).

Review of the significant change in status "Minimum Data Set" (MDS) dated 12/11/19 revealed a "Brief Interview for Mental Status" (BIMS) score of 13 indicating normal cognition. The resident received insulin injections.

The 12/11/19 Nutritional "Care Area Assessment" (CAA) noted R30's diagnosis of diabetes. The CAA lacked additional information/assessments related to blood glucose monitoring and/or physician parameters for blood sugars.

The 10/31/18 "Care Plan" included measurable goals and interventions related to R30's diagnosis of diabetes. The care plan lacked interventions related to blood glucose monitoring and physician ordered parameters for blood glucose levels. The care plan also lacked interventions related to use of insulin.

On 03/02/19, the physician ordered blood glucose monitoring four times daily.

On 12/03/19, the physician ordered "as needed" insulin for blood glucose levels above 400 mg/dl. On 12/13/19, the physician ordered routine administration of insulin three times daily with meals.

Review of the medication administration record (MAR) for 12/02/2019 through 01/07/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 756	Continued From page 32	F 756		

revealed 26 incidents when blood glucose monitoring resulted in levels greater than 400 mg/dl. Of those 26 incidents, staff failed to administer as needed insulin five times as follows:

1) 12/02/19: blood glucose of 477 mg/dl - no insulin administered
2) 12/05/19: blood glucose of 577 mg/dl - no insulin administered
3) 12/08/19: blood glucose of 408 mg/dl - no insulin administered
4) 12/16/19: blood glucose of 563 mg/dl - no insulin administered
5) 12/24/19: blood glucose of 416 mg/dl - no insulin administered

Consultant Pharmacist K completed monthly drug regimen reviews on 11/26/19 and 12/23/19. The pharmacist failed to identify drug irregularities related to staff failure to administer insulin when the blood glucose levels were greater than 400 multiple times from 12/02/19 - 12/24/19.

During an observation on 01/07/20 at 11:44 AM, Licensed Nurse (LN) A completed blood glucose testing for R30. LN A obtained a result of 409 mg/dl and subsequently administered additional insulin as per physician orders.

During an interview on 01/09/20 at 10:19 AM Administrative Nurse C reported she was unaware of the six missed doses of insulin when R30's blood glucose level was greater than 400 mg/dl.

During an interview on 01/13/20 at 11:00 AM Consultant Pharmacist K reported she monitored the blood glucose results of residents who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 756	Continued From page 33 received insulin only if there was a recent change in insulin. Review of the undated facility policy "Consultant Pharmacist Services Provider" revealed the pharmacist would submit a written report and recommendations for each review. The policy directed the pharmacist to review the medication regimen monthly for each resident, utilizing federally-mandated standards of care in addition to other applicable standards and documenting findings in the resident's medical record. The facility failed to have a system in place to ensure reporting of drug irregularities (failure to administer supplemental insulin as ordered by the physician for blood glucose levels greater than 400 mg/dl) to the physician and director of nursing for R30.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 757	Continued From page 34	F 757		

consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents, with five residents sampled for unnecessary medications. Based on observation, interview, and record review the facility failed to ensure one of five residents did not receive unnecessary medications when staff failed to respond to elevated blood glucose levels over 400 milligrams per deciliter (mg/dl) for Resident (R) 30 with the administration of supplemental insulin as ordered by the physician.

Findings included:

- Review of Resident (R) 30's signed "Physician Orders" dated 11/26/19 revealed the following diagnosis: type 2 diabetes mellitus with hyperglycemia (disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in abnormal metabolism of carbohydrates and elevated levels of glucose in the blood and urine).

Review of the significant change in status "Minimum Data Set" (MDS) dated 12/11/19 revealed a "Brief Interview for Mental Status" (BIMS) score of 13 indicating intact cognition. The resident received insulin injections.

The 12/11/19 "Care Area Assessment" (CAA) for nutrition noted R30's diagnosis of diabetes. The CAA lacked additional information/assessments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

(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 757	Continued From page 35	F 757		

related to blood glucose monitoring and/or physician parameters for blood sugars.

The 10/31/18 "Care Plan" included measurable goals and interventions related to R30's diagnosis of diabetes. The care plan lacked interventions related to blood glucose monitoring and physician ordered parameters for blood glucose levels. The care plan also lacked interventions related to use of insulin.

On 03/02/19, the physician ordered blood glucose monitoring four times daily.

On 12/03/19, the physician ordered "as needed" insulin for blood glucose levels above 400 milligrams per deciliter (mg/dl).

On 12/13/19, the physician ordered routine administration of insulin three times daily with meals.

Review of the medication administration record (MAR) for 12/02/2019 through 01/07/2020 revealed 26 incidents when blood glucose monitoring resulted in levels greater than 400 mg/dl. Of those 26 incidents, staff failed to administer as needed insulin five times as follows:

1)12/02/19: blood glucose of 477 mg/dl with no insulin administered
2)12/05/19: blood glucose of 577 mg/dl with no insulin administered
3)12/08/19: blood glucose of 408 mg/dl with no insulin administered
4)12/16/19: blood glucose of 563 mg/dl with no insulin administered
5)12/24/19: blood glucose of 416 mg/dl with no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175489	A. BUILDING _____ B. WING _____	01/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE SUNSET HOME INC	601 E MAIN STREET PRETTY PRAIRIE, KS 67570

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F 757	Continued From page 36 insulin administered During an observation on 01/07/20 at 11:44 AM Licensed Nurse (LN) A completed blood glucose testing for R30. LN A obtained a result of 409 mg/dl and subsequently administered additional insulin as per physician orders. During an interview on 01/09/20 at 10:19 AM Administrative Nurse C reported she did not know of the six missed doses of insulin when R30's blood glucose level were greater than 400 mg/dl. Review of the facility policy for Diabetic Management/Insulin dated 06/28/17 revealed Accuchecks (a form of blood glucose monitoring) would be obtained as ordered by the physician, by a Certified Medication Aide (CMA) or charge nurse, and recorded in the electronic record for the appropriate time. Each resident should have a physician ordered parameter for blood glucose levels requiring physician notification. The facility failed to respond to elevated blood glucose levels over 400 mg/dl for Resident (R) 30 with the administration of supplemental insulin as ordered by the physician.	F 757		