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	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Home Inc	620 Second Avenue Concordia, KS 66901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to maintain an environment that promoted the dignity of Resident (R) 34, who had blood sugar testing and insulin administration, and R9, who also had insulin administration in the facility's dining room with other residents, staff, and visitors.0 This deficient practice placed the residents at risk for an undignified experience and embarrassment. Findings included: - On 03/25/25 at 11:21 AM, Licensed Nurse (LN) I performed a finger stick to obtain a drop of blood for testing R4's blood sugar level. R34, seated across the same table, stated, I'm glad that's not me, I don't like needles. LN I then retrieved an insulin pen and injected insulin (a hormone that lowers the level of glucose in the blood) subcutaneously (beneath the skin) into R4's right arm at the dining room table. On 03/25/25 at 11:29 AM, LN I administered R9's insulin subcutaneously while seated in the dining room. The table R9 sat at had two other residents and a visitor also seated at the same table at the time of the administration of insulin. 03/26/25 at 09:25 AM, LN I reported giving insulin in the dining room if the resident wanted. LN I stated R34 had joked about needles, and the other residents and visitors did not mind if insulin was administered in the dining room, but could give the insulin and check blood sugars in the residents' rooms. On 03/26/25 at 01:50 PM, Administrative Nurse D verified that the residents could receive insulin privately if the resident chose to. The facility's undated Right to Dignity policy documented the facility would promote care for elders in a manner and an environment that maintained and enhanced each elder's dignity and respect in full recognition of the elder's individuality. The facility failed to maintain an environment that promoted the dignity of R34 and R9, who had insulin administered in the dining room with other residents, staff, and visitors present. The deficient practice placed the residents at risk for an undignified experience and embarrassment.

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.

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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview and record review, the facility failed to keep Resident (R) 35 free from verbal abuse during transport in the facility bus. This deficient practice placed R35 at risk for fear or mental anguish. Findings included: - R35's electronic medical record included diagnoses for cerebral infarction (stroke) causing hemiplegia (refers to complete paralysis on one side of the body) affecting the left side, cerebral edema (swelling of the brain tissue), and muscle weakness. The admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R35 was dependent on staff for mobility, dressing, and hygiene. He used a manual wheelchair, had one non-injury fall, and a history of falls before admission. R35's Care Plan, dated 11/04/24, directed staff to transfer R35 with two staff and a total mechanical lift, initiated 11/04/24. Provide a Broda chair (specialized wheelchair) due to his inability to safely sit in a regular wheelchair, initiated: 11/06/2024 The Grievance Log complaint of 11/04/25 documented on 11/04/24 a new resident (R35) complained of being treated horribly by the transportation aide on his way to this facility. He reported he was yelled at, and cursed at several times because he kept sliding out of his wheelchair. He reported he was told, F***, I have stopped every five miles for you, and I am not going to keep stopping for this. R35 felt like he shouldn't be yelled at for something he could not help. He reported he slid completely out of his wheelchair and then she got really mad and started yelling. The resident also called his family and told them how he was treated. Resolution: The Transportation Aide was educated on Abuse/Neglect/Exploitation. The Witness statement from the transportation Aide, dated 11/01/24, stated she strapped the resident (R35) in the van securely, but she had to stop several times to pull him back up in his wheelchair. He told her he was sliding himself down. The transportation aide wrote she did show some frustration with him and told herself she needed to calm down. At one point his bottom was completely off the wheelchair and she could not pull him up, so she lowered him to the floor. She called the nursing home who sent out two aides to assist her. The admission Note dated 11/04/24 at 05:21 PM documented a new male resident was transported via the facility van and wheelchair. R35 required a full lift. He leaned to his left and had no use of his left arm. R35 denied pain. The Social Services Note dated 11/04/24 at 02:15 PM documented the SSD introduced herself to R35 in his room. He was lying in bed and asked her to adjust his blankets and turn up the heater because he was cold. The SSD assisted R35 with putting away his personal items. The note lacked documentation of any complaint of abuse. The Progress Note dated 11/05/24 at 05:16 AM documented R35 did not sleep at all last night. Staff (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted him with repositioning about every 30 minutes during the night shift. R35 would throw the left side of his body out of bed. The nurse finally said to him You have to be pushing yourself this way in order for you to be off the bed like this. R35 responded, That's what they said in the hospital. The nurse educated him on ways to better keep himself from pushing himself out of bed and he did much better after the education. The Progress Note dated 11/6/24 at 04:47 AM documented R35 continued to adjust well to the facility. R35 slid out of his wheelchair at shift change around 06:00 PM. R35 stated he slid out of his chair onto the floor and then laid down. He denied hitting his head. A complete assessment was completed along with risk management. R35 slept well all night and only rang this morning for pain medication due to left hip pain. On 03/26/25 at 12:45 PM, R35 laid in bed, and a Broda chair with a three-inch pommel (raised area in the cushion to help prevent forward slipping) cushion was in his room. R35 was alert and oriented and reported he was verbally abused on the van ride to the facility when he was first admitted . R35 stated his wheelchair did not have the thing in the seat (pommel) that kept him from sliding. R35 reported the driver repeatedly got upset with him and cursed when he kept sliding forward during the ride. He reported no further problems when transported by the facility. On 03/26/25 at 02:18 PM, Certified Nurse Aide (CNA) and Transportation Aide O, stated she took a regular wheelchair to transport R35 from the previous facility, he did not come with his own wheelchair. CNA O stated the previous facility did not give our facility any information that the resident was at risk of sliding forward. CNA O verified she was angry but had not cursed while transporting R35 in November 2024. Training for transporting residents was a class every two years with a state agency. She stated they have to demonstrate securing a resident during the class. She stated after the incident the administration educated her for ANE. On 03/26/25 at 02:32 PM, Administrative Staff A verified the facility had not reported the allegation of verbal abuse to the state agency or investigated it that he knew of (he was not employed here in November). He stated the only documentation the facility could find was the grievance log and the transportation aide's note. The facility's undated Abuse, Neglect, and Exploitation policy stated all residents of the facility would be free of physical, emotional, and sexual abuse, neglectful treatment, and misappropriation of funds and resources. The policy stated verbal abuse included willfully disparaging and derogatory terms to residents or their families or within their hearing. Residents and their families could report a grievance orally or in writing and the Grievance Officer would immediately report the incident to the administrator of the facility. Any allegations of all types of staff-to-resident abuse would be reported to the facility administrator and to other official agencies including the State Agency. The policy stated witness statements would be obtained, an investigation performed, and a written report filed. The facility failed to keep R35 free from verbal abuse during transport in the facility bus. This deficient practice placed R35 at risk for fear or mental anguish.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure staff reported an allegation of verbal abuse from Resident (R) 35 to the administrator immediately to investigate. This placed R35 at risk for ongoing abuse and or mistreatment. Findings included: - R35's electronic medical record included diagnoses for cerebral infarction (stroke) causing hemiplegia (refers to complete paralysis on one side of the body) affecting the left side, cerebral edema (swelling of the brain tissue), and muscle weakness. The admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R35 was dependent on staff for mobility, dressing, and hygiene. He used a manual wheelchair, had one non-injury fall, and had a history of falls before admission. R35's Care Plan, dated 11/04/24, directed staff to transfer R35 with two staff and a total mechanical lift, initiated 11/04/24. Provide a Broda chair (specialized wheelchair) due to his inability to safely sit in a regular wheelchair, initiated: 11/06/2024 The Grievance Log complaint of 11/04/25 documented on 11/04/24 a new resident (R35) complained of being treated horribly by transportation aide on his way to this facility. He reported he was yelled at, and cursed at several times because he kept sliding out of his wheelchair. He reported he was told, F***, I have stopped every five miles for you, and I am not going to keep stopping for this. R35 felt like he shouldn't be yelled at for something he could not help. He reported he slid completely out of his wheelchair and then she got really mad and started yelling. The resident also called his family and told them how he was treated. Resolution: The Transportation Aide was educated on Abuse/Neglect/Exploitation. The Witness Statement from the transportation Aide, dated 11/01/24, stated she strapped the resident (R35) in the van securely, but she had to stop several times to pull him back up in his wheelchair. He told her he was sliding himself down. The transportation aide wrote she did show some frustration with him and told herself she needed to calm down. At one point his bottom was completely off the wheelchair and she could not pull him up, so she lowered him to the floor. She called the nursing home who sent out two aides to assist her. The admission Note dated 11/04/24 at 05:21 PM documented a new male resident was transported via the facility van and wheelchair. R35 required a full lift. He leaned to his left and had no use of his left arm. R35 denied pain. The Social Services Note dated 11/04/24 at 02:15 PM documented the SSD introduced herself to R35 in his room. He was lying in bed and asked her to adjust his blankets and turn up the heater because he was cold. The SSD assisted R35 with putting away his personal items. The note lacked documentation of any complaint of abuse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 11/05/24 at 05:16 AM documented R35 did not sleep at all last night. Staff assisted him with repositioning about every 30 minutes during the night shift. R35 would throw the left side of his body out of bed. The nurse finally said to him You have to be pushing yourself this way in order for you to be off the bed like this. R35 responded, That's what they said in the hospital. The nurse educated him on ways to better keep himself from pushing himself out of bed and he did much better after the education. The Progress Note dated 11/6/24 at 04:47 AM documented R35 continued to adjust well to the facility. R35 slid out of his wheelchair at shift change around 06:00 PM. R35 stated he slid out of his chair onto the floor and then laid down. He denied hitting his head. A complete assessment was completed along with risk management. R35 slept well all night and only rang this morning for pain medication due to left hip pain. On 03/26/25 at 12:45 PM, R35 was lying in bed and a Broda chair with a three-inch pommel (raised area in the cushion to help prevent forward slipping) cushion was in his room. R35 was alert and oriented and reported he was verbally abused on the van ride to the facility when he was first admitted . R35 stated his wheelchair did not have the thing in the seat (pommel) that kept him from sliding. R35 reported the driver repeatedly got upset with him and cursed when he kept sliding forward during the ride. He reported no further problems when transported by the facility. On 03/26/25 at 02:18 PM, Certified Nurse Aide (CNA) and Transportation Aide O, stated she took a regular wheelchair to transport the resident from the previous facility, he did not come with his own wheelchair. CNA O stated the previous facility did not give our facility any information that the resident was at risk of sliding forward. CNA O verified she was angry but did not curse while transporting R35 in November 2024. Training for transporting residents was a class every two years with a state agency. She stated they have to demonstrate securing a resident during the class. She stated after the 11/04/24 incident the administration educated her for ANE. On 03/26/25 at 02:32 PM, Administrative Staff A verified the facility had not reported the allegation of verbal abuse to the state agency or investigated it that he knew of (he was not employed here in November). He stated the only documentation the facility could find was the Grievance Log and the transportation aide's note. The facility's undated Abuse, Neglect, and Exploitation policy stated all residents of the facility would be free of physical, emotional, and sexual abuse, neglectful treatment, and misappropriation of funds and resources. The policy stated verbal abuse included willfully disparaging and derogatory terms to residents or their families or within their hearing. Residents and their families could report a grievance orally or in writing and the Grievance Officer would immediately report the incident to the administrator of the facility. Any allegations of all types of staff-to-resident abuse would be reported to the facility administrator and other official agencies including the State Agency. The policy stated witness statements would be obtained, an investigation performed, and a written report filed. The facility failed to report an allegation of verbal abuse from Resident (R) 35 to the administrator and the state agency. This placed R35 at risk for ongoing abuse and or mistreatment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to thoroughly investigate the allegation of verbal abuse immediately. This placed Resident (R) 35 at risk for ongoing abuse and or mistreatment. Findings included: - R35's electronic medical record included diagnoses for cerebral infarction (stroke) causing hemiplegia (refers to complete paralysis on one side of the body) affecting the left side, cerebral edema (swelling of the brain tissue), and muscle weakness. The admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R35 was dependent on staff for mobility, dressing, and hygiene. He used a manual wheelchair, had one non-injury fall, and had a history of falls before admission. R35's Care Plan, dated 11/04/24, directed staff to transfer R35 with two staff and a total mechanical lift, initiated 11/04/24. Provide a Broda chair (specialized wheelchair) due to his inability to safely sit in a regular wheelchair, initiated: 11/06/2024 The Grievance Log complaint of 11/04/25 documented on 11/04/24 a new resident (R35) complained of being treated horribly by a transportation aide on his way to this facility. He reported he was yelled at, and cursed at several times because he kept sliding out of his wheelchair. He reported he was told, F***, I have stopped every five miles for you, and I am not going to keep stopping for this. R35 felt like he shouldn't be yelled at for something he could not help. He reported he slid completely out of his wheelchair and then she got really mad and started yelling. The resident also called his family and told them how he was treated. Resolution: The Transportation Aide was educated on Abuse/Neglect/Exploitation. The Witness Statement from Transportation Aide O, dated 11/01/24, stated she strapped the resident (R35) in the van securely, but she had to stop several times to pull him back up in his wheelchair. He told her he was sliding himself down. The transportation aide wrote she did show some frustration with him and told herself she needed to calm down. At one point his bottom was completely off the wheelchair and she could not pull him up, so she lowered him to the floor. She called the nursing home who sent out two aides to assist her. The admission Note dated 11/04/24 at 05:21 PM documented a new male resident was transported via the facility van and wheelchair. R35 required a full lift. He leaned to his left and had no use of his left arm. R35 denied pain. The Progress Note dated 11/05/24 at 05:16 AM documented R35 had not sleep at all last night. Staff assisted him with repositioning about every 30 minutes during the night shift. R35 would throw the left side of his body out of bed. The nurse finally said to him You have to be pushing yourself this way in order for you to be off the bed like this. R35 responded, That's what they said in the hospital. The nurse educated him on ways to better keep himself from pushing himself out of bed and he did much better after the education. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note, dated 11/6/24 at 04:47 AM, documented R35 continued to adjust well to the facility. R35 slid out of his wheelchair at shift change around 06:00 PM. R35 stated he slid out of his chair onto the floor and then laid down. He denied hitting his head. A complete assessment was completed along with risk management. R35 slept well all night and only rang this morning for pain medication due to left hip pain. On 03/26/25 at 12:45 PM, R35 was lying in bed and a Broda chair with a three-inch pommel (raised area in the cushion to help prevent forward slipping) cushion was in his room. R35 was alert and oriented and reported he was verbally abused on the van ride to the facility when he was first admitted . R35 stated his wheelchair did not have the thing in the seat (pommel) that kept him from sliding. R35 reported the driver repeatedly got upset with him and cursed when he kept sliding forward during the ride. He reported no further problems when transported by the facility. On 03/26/25 at 02:18 PM, Certified Nurse Aide (CNA)/Transportation Aide O, stated she took a regular wheelchair to transport the resident from the previous facility, he did not come with his own wheelchair. CNA O stated the previous facility did not give our facility any information that the resident was at risk of sliding forward. CNA O verified she was angry but had not cursed while transporting R35 in November 2024. Training for transporting residents was a class every two years with a state agency. She stated they have to demonstrate securing a resident during the class. She stated after the 11/04/24 incident the administration educated her for ANE. On 03/26/25 at 02:32 PM, Administrative Staff A verified the facility had not reported the allegation of verbal abuse to the state agency or investigated it that he knew of (he was not employed here in November). He stated the only documentation the facility could find was the Grievance Log and Transportation Aide O's note. The facility's undated Abuse, Neglect, and Exploitation policy stated all residents of the facility would be free of physical, emotional, and sexual abuse, neglectful treatment, and misappropriation of funds and resources. The policy stated verbal abuse included willfully disparaging and derogatory terms to residents or their families or within their hearing. Residents and their families could report a grievance orally or in writing and the Grievance Officer would immediately report the incident to the administrator of the facility. Any allegations of all types of staff-to-resident abuse would be reported to the facility administrator and to other official agencies including the State Agency. The policy stated witness statement would be obtained, an investigation performed, and a written report filed. The facility failed to thoroughly investigate the allegation of verbal abuse immediately. This placed R35 at risk for ongoing abuse and or mistreatment.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on the record review and interview, the facility failed to ensure that Resident (R) 126's transfer or discharge was documented in the resident's medical record and appropriate information was communicated to the receiving healthcare institution or provider. This placed R126 at risk for delayed treatment at the receiving institution. Findings included: - R126's Electronic Medical Record (EMR) recorded diagnoses of dorsalgia (discomfort occurring anywhere on the spine or back, ranging from mild to disabling), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, chronic (persisting for a long period) kidney disease, diabetes mellites (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN - elevated blood pressure), atrial fibrillation (rapid, irregular heartbeat), multiple fractures (broken bone) of ribs, low back pain and history of disease of the blood-forming organs. The admission Minimum Data Set (MDS), dated [DATE], documented R126 had severe cognitive impairment, verbal behavioral symptoms directed toward others, and rejection of care that occurred one to three days of the look-back period. R126 required partial/moderate assistance with toileting and personal hygiene, upper body dressing, mobility, and transfers. R126 required substantial/maximal assistance with showering and lower body dressing. R126 had occasional incontinence of urine and received as-needed pain medication for almost constant pain, which affected sleep, therapy participation, and day-to-day activities. The MDS further documented that R126 had an unhealed stage two (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters) pressure ulcer on admission. R126's Care Plan dated 12/19/24 documented R126 required staff assistance with activities of daily living related to limited mobility and physical decline. The care plan documented R126 was alert with confusion, and required assistance of one staff member with bathing, bed mobility, dressing, personal and toileting hygiene, and toilet use. The care plan further documented R126 had a stage two pressure ulcer to the middle of the spine, had the potential to be verbally aggressive towards staff, and had weight loss. The Progress Note dated 12/05/24 at 04:51 PM documented that R126 had been admitted from a hospital with a self-care deficit. The progress note further documented R126 had a two cm in length by 1.5 cm width red area to the middle spine with one cm length by one cm width open dried area. The Progress Note dated 12/25/24 at 02:45 PM documented R 126 found lying on the floor. The exam of R126's skin showed R126 had landed on his back, where he had an open wound. R126 was able to move all extremities without difficulty and complained of back pain. Vital signs obtained of temperature of 97.4 degrees Fahrenheit, blood pressure of 172/103, pulse 64, respiration 22, and oxygen saturation of 89 percent (%). The note further documented neurological checks initiated, the resident family member was notified, and the physician was notified by fax. The Progress Note dated 12/25/24 at 11:59 PM documented R126 rested in bed with eyes closed, no further injuries found, neurological check, and vital signs were within normal limits. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 12/26/24 at 08:18 AM documented R126 continued with fall follow-up assessment. R126 was sleepy but easily arousable. The progress note further documented no new areas of concern and moved extremities without difficulties. The Progress Note on 12/27/24 at 09:52 AM, documented that the facility received a call from the hospital that R126 was being transferred to them from the local hospital and requested information on the last given medications and treatments while R126 was at the facility. The note further documented that the facility nurse was to fax the medication and treatment administration records to the receiving hospital of R126. The medical record lacked nursing assessment and transfer documentation as to why or how R126 left the facility. On 03/26/25 at 02:30 PM, Administrative Nurse D verified the medical record lacked the assessment, reason, and to where R126 had been sent. Administrative Nurse D stated that the nurse who worked during that time no longer works at the facility and should have completed the transfer assessments and records. The facility's Transfers Between Facilities and Hospital policy, dated, stated that it was the policy of the facility to expedite communication between all units of the acute hospital and the facility for the best care of the elder. Transfers between the acute hospital and the facility would be carried out efficiently and effectively. When transferring elders, these records will be sent from the facility to an acute hospital, an elder transfer and referral record must be completed in full and sent with the elder including on this record the elder's normal level of Activities of Daily Living before the illness requiring transfer to the acute hospital, copies of the most current Interdisciplinary Notes and Medication Administration Records will be sent with the elder. If the elder is sent to the Emergency Department under emergency circumstances, copies of the clinical record are to accompany the elder: the transfer record should be completed as soon as possible, along with completed nurses' notes and medication record, and sent to the acute hospital. The facility failed to ensure that the transfer/discharge was documented in the resident's medical record and appropriate information was communicated to the receiving health care institution or provider which placed R126 at risk for delayed treatment in the receiving facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to provide Resident (R) 126 with an appropriate bed hold policy as required. This deficient practice placed the resident at risk of being unable to return to the facility in the same room or bed. Findings included: -R126's Electronic Medical Record (EMR) recorded diagnoses of dorsalgia (discomfort occurring anywhere on the spine or back, ranging from mild to disabling), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, chronic (persisting for a long period) kidney disease, diabetes mellites (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN - elevated blood pressure), atrial fibrillation (rapid, irregular heartbeat), multiple fractures (broken bone) of ribs, low back pain and history of disease of the blood-forming organs. The admission Minimum Data Set (MDS), dated [DATE], documented R126 had severe cognitive impairment, verbal behavioral symptoms directed toward others, and rejection of care that occurred one to three days of the look-back period. R126 required partial/moderate assistance with toileting and personal hygiene, upper body dressing, mobility, and transfers. R126 required substantial/maximal assistance with showering and lower body dressing. R126 had occasional incontinence of urine, and received as-needed pain medication for almost constant pain, which affected sleep, therapy participation, and day-to-day activities. The MDS further documented that R126 had an unhealed stage two (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters) pressure ulcer on admission. R126's Care Plan dated 12/19/24 documented R126 required staff assistance with activities of daily living related to limited mobility and physical decline. The care plan documented R126 was alert with confusion, and required assistance of one staff member with bathing, bed mobility, dressing, personal and toileting hygiene, and toilet use. The care plan further documented R126 had a stage two pressure ulcer to the middle of the spine, had the potential to be verbally aggressive towards staff, and had weight loss. The Progress Note dated 12/05/24 at 04:51 PM documented that R126 had been admitted from a hospital with a self-care deficit. The progress note further documented R126 had a two centimeters (cm) in length by 1.5 cm in width red area to the middle spine with one cm length by one cm width open dried area. The Progress Note dated 12/25/24 at 02:45 PM documented R 126 found lying on the floor. The exam of R126's skin showed R126 had landed on his back, where he had an open wound. R126 was able to move all extremities without difficulty and complained of back pain. Vital signs obtained of temperature of 97.4 degrees Fahrenheit, blood pressure of 172/103, pulse 64, respirations 22, and oxygen saturation of 89 percent (%). The note further documented neurological checks initiated, the resident family member was notified, and the physician was notified by fax. The Progress Note dated 12/25/24 at 11:59 PM documented R126 rested in bed with eyes closed, no (continued on next page)

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	175422	A. Building B. Wing	03/26/2025

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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further injuries found, neurological check, and vital signs were within normal limits. The Progress Note dated 12/26/24 at 08:18 AM, documented R126 continued with fall follow-up assessment. R126 was sleepy but easily arousable. The progress note further documented no new areas of concern and moved extremities without difficulties. The Progress Note on 12/27/24 at 09:52 AM, documented that the facility received a call from the hospital that R126 was being transferred to them from the local hospital and requested information on the last given medications and treatments while R126 was at the facility. The note further documented that the facility nurse was to fax the medication and treatment administration records to the receiving hospital of R126. The medical record lacked nursing assessment and transfer documentation as to why or how R126 left the facility. On 03/26/25 at 02:30 PM, Administrative Nurse D verified the medical record lacked the assessment, reason, and to where R126 had been sent, and provided the bed hold form. Administrative Nurse D stated that the nurse who worked during that time no longer works at the facility and should have completed the transfer assessments and records. The facility's undated Bed Hold Policy documented before this facility transfers a resident to a hospital or the resident goes on therapeutic leave, the facility will provide information to the resident and/or resident representative that specifies: the duration of the state bed-hold policy during which the resident is permitted to return and resume residency in the facility: the reserve bed payment policy in the state plan; the facility's policies regarding bed-hold period, which are consistent with the law permitting the resident to return. The nurse responsible for the preparation of information that would accompany a resident when transferred to another healthcare facility would include the facility's policy for retaining the resident's current bedroom while absent from the facility. The facility failed to provide R126's representative with a bed-hold policy. This deficient practice placed R126 at risk of being uninformed of bed-hold requirements.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to provide an appropriate cover or dressing for Resident (R) 11's open pressure ulcer (PU) of her left heel. This deficient practice placed R11 at risk for pain or infection. Findings included: - R11's Electronic Medical Record documented diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion) and left hip fracture (broken bone). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired decision-making. The MDS documented R11 required moderate staff assistance for bathing and maximum staff assistance for dressing her lower body and shoes. The MDS documented R11 had PU and PU care was provided. R11's Care Plan, dated 01/10/25, directed staff to monitor and document wound size, depth, granulation, and progress in healing. Notify the physician as indicated and report any signs of infection. The Physician Order, dated 03/25/25, directed staff to dress R11's left heel with saline-moistened promogram prisma (a wound dressing designed to maintain a moist environment and provide antimicrobial protection) to the wound bed followed by mepilex border (a self-adherent, five-layer foam dressing with a soft silicone border designed to maintain a moist wound environment, absorb drainage, and prevent pressure ulcers while minimizing pain and trauma). On 03/25/25 at 07:42 AM, R11 finished eating 100% of her breakfast. She wore house slippers with an open back and rubber soles. R11 carried one sock. Certified Medication Aide (CMA) S took R11 to her room, used a gait belt, and transferred her to the toilet. R11 had no dressing or covering on her left heel PU. CMA S requested a nurse to assess a skin tear. Administrative Staff D came to the room and left to call the wound clinic for directions on whether to apply a dressing to R11's PU. At 08:07 AM, Licensed Nurse (LN) I came in and treated the skin tear to R11's left inner calf, then assisted R11 to dress and transfer from the toilet to her wheelchair without a dressing or covering for the PU on her left heel. LN I took R11 to a recliner in the commons area and used a gait belt to transfer R11 into a recliner. LN I stated R11 had an appointment at the wound clinic at 09:00 AM and she had a shower at 06:00 AM. At 08:18 AM, LN I called the wound clinic and they directed her to cover the wound for now. LN I took R11 back to her room, cleansed the left heel wound, and applied a mepilex dressing to the wound. The PU was to the outside of the left heel, approximately two centimeters (cm) by two cm, with dry slough (dead tissue) visible. Staff were unable to determine if there had been drainage as the resident had worn fuzzy gray house slippers after her shower. On 03/25/25 at 08:33 AM, Certified Nurse Aide (CNA) N stated R11 liked to get up early and shower around 06:00 AM. CNA N stated on shower days when the resident was to go to wound care, she had been instructed to remove the old wound dressing and inform the nurse of that. On 03/25/25 at 10:17 AM, Administrative Nurse E verified an open wound should be covered at all times unless the physician ordered something different. The facility failed to provide a policy for treatment of pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide an appropriate cover or dressing for R11's open PU on her left heel. This deficient practice placed R11 at risk for pain or infection.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 10 had physician-ordered fluid intake, which placed R10 at risk of ongoing urinary tract infections. Findings included: - R10's Electronic Medical Record (EMR) included diagnoses of heart failure, weakness, intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and chronic (persisting for a long period) kidney disease. The Quarterly Minimum Data Set (MDS) dated [DATE], documented R10 had intact cognition, no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R10 required setup or clean-up assistance with eating and substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and was dependent on mobility and transfers. R10 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag), was incontinent of bowel, had renal (pertaining to kidneys) insufficiency, and neurogenic bladder. The MDS further documented that R10 had received oxygen, speech, occupational and physical therapy. R10's Care Plan, dated 02/13/25, documented R10 had a catheter in place due to a neurogenic bladder. The Care Plan directed staff to monitor and document intake and output and report to the Medical Doctor (MD) signs or symptoms of a urinary tract infection. The Physician Order, dated 01/29/25, ordered R10 to drink two quarts (or eight cups) of water daily (1920 cubic centimeters - cc's) every 24 hours. The Progress Note dated 01/27/25 at 11:15 AM documented R10 had returned from the hospital with diagnoses of an acute urinary tract infection (UTI - an infection in any part of the urinary system), acute and chronic renal failure, and dehydration. The note further documented that R10 had an indwelling catheter due to retention. The Progress Note dated 02/11/25 at 11:54 PM documented that R10 had been sent to the emergency department and had started an antibiotic due to having a urinary tract infection. Upon review of the EMR fluid intake record from 02/24/25 to 03/12/25 (last recorded intake) revealed that R10 lacked the amount of physician-ordered intake of two quarts daily. On 03/26/25 at 07:54 AM, R10 sat in the dining room eating breakfast independently. R10 had two 240 cc cups with sipper lids and handles placed on the table with her meal. On 03/26/25 at 07:50 AM, Dietary Staff (DS) BB reported that the kitchen staff was not currently (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	keeping track of anyone's fluid intake. DS BB reported that the dietary staff always placed a cup of water and a cup of juice at each meal. DS BB also stated that coffee, milk, and refills are also offered to the residents at mealtime. On 03/26/25 at 07:59 AM, Certified Medication Aide (CMA) R reported that the dietary staff kept track of fluid intake for residents who ate in the dining room, and the nursing staff kept track of the fluids for residents who chose to eat their meals in their rooms. On 03/26/25 at 09:01 AM, Licensed Nurse (LN) I stated she was not aware of the required fluid intake for R10. On 03/27/25 at 01:53 PM, Administrative Nurse D verified that R10 had a physician order of two quarts of water every 24 hours and should be included in the care plan. The facility failed to provide a urinary tract infection prevention policy. The facility failed to ensure R10 had a physician-ordered fluid intake, which placed R10 at risk of ongoing urinary tract infections.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 10 had physician-ordered fluid intake, which placed R10 at risk of ongoing dehydration and urinary tract infections. Findings included: - R10's Electronic Medical Record (EMR) included diagnoses of heart failure, weakness, intellectual disabilities (a significantly below-average score on a test of mental ability or intelligence and limitations in the ability to function in areas of daily life), neuromuscular dysfunction of the bladder (the muscles that control the flow of urine out of the body do not relax and prevent the bladder from fully emptying), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and chronic (persisting for a long period) kidney disease. The Quarterly Minimum Data Set (MDS) dated [DATE], documented R10 had intact cognition, no signs or symptoms of delirium (sudden severe confusion, disorientation, and restlessness) or psychosis (any major mental disorder characterized by a gross impairment in reality perception), or exhibited behaviors. R10 required setup or clean-up assistance with eating and substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and was dependent with mobility and transfers. R10 had an indwelling catheter (tube placed in the bladder to drain urine into a collection bag), was incontinent of bowel, had renal (pertaining to kidneys) insufficiency, and neurogenic bladder. The MDS further documented that R10 had received oxygen, speech, occupational and physical therapy. R10's Care Plan, dated 02/13/25, documented R10 had a catheter in place due to a neurogenic bladder. The Care Plan directed staff to monitor and document intake and output and report to the Medical Doctor (MD) signs or symptoms of a urinary tract infection. The Physician Order dated 01/29/25 ordered R10 to drink two quarts (or eight cups) of water daily (1920 cubic centimeters - cc's) every 24 hours. The Progress Note dated 01/27/25 at 11:15 AM documented R10 had returned from the hospital with diagnoses of an acute urinary tract infection (UTI - an infection in any part of the urinary system), acute and chronic renal failure, and dehydration. The note further documented that R10 had an indwelling catheter due to retention. The Progress Note dated 02/11/25 at 11:54 PM documented that R10 had been sent to the emergency department and had started an antibiotic due to having a urinary tract infection. Upon review of the EMR fluid intake record from 02/24/25 to 03/12/25 (last recorded intake) revealed that R10 lacked the amount of physician-ordered intake of two quarts daily. On 03/26/25 at 07:54 AM, R10 sat in the dining room eating breakfast independently. R10 had two 240 cc cups with sipper lids and handles placed on the table with her meal. On 03/26/25 at 07:50 AM, Dietary Staff (DS) BB reported that the kitchen staff was not currently keeping track of anyone's fluid intake. DS BB reported that the dietary staff always placed a cup of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water and a cup of juice at each meal. DS BB also stated that coffee, milk, and refills were also offered to the residents at mealtime. On 03/26/25 at 07:59 AM, Certified Medication Aide (CMA) R reported that the dietary staff kept track of fluid intake for residents who ate in the dining room, and the nursing staff kept track of the fluids for residents who chose to eat their meals in their rooms. On 03/26/25 at 09:01 AM, Licensed Nurse (LN) I stated she was not aware of the required fluid intake for R10. On 03/27/25 at 01:53 PM, Administrative Nurse D verified that R10 had a physician order of two quarts of water every 24 hours and should be included in the care plan. The facility failed to provide a urinary tract infection prevention policy. The facility's undated Hydration policy documented it is the policy of the facility to ensure that elders receive sufficient fluid to maintain proper hydration and health. When the elder developed a clinical condition that placed him/her at risk for dehydration, interventions acceptable and appropriate for the elder would be implemented. The facility failed to ensure R10 had a physician-ordered fluid intake, which placed R10 at risk of ongoing dehydration and urinary tract infections.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility's consultant pharmacist failed to notify the director of nursing or R34's physician of the lack of monitoring R34's blood pressure as the physician ordered to monitor the effectiveness of her medication, placing R34 at risk of receiving unnecessary medication. Findings included: - R34's Electronic Medical Record documented diagnoses of hypertension (HTN - elevated blood pressure), transient cerebral ischemic attack (TIA - temporary episode of inadequate blood supply to the brain), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R34 received antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (narcotic) medications. R34's Care Plan, dated 02/17/25, directed staff to consult with a pharmacist as needed, monitor, and report adverse reactions to medication therapy. The Physician Order, dated 08/31/24, directed staff to administer losartan (blood pressure lowering drug) 100 milligrams (mg) daily. The order stated to hold the drug if R34's systolic blood pressure (SB/P) was less than 100 mmHg (millimeters of mercury) or the diastolic blood pressure (DB/P) was less than 60 mmHg. R34's blood pressure documentation revealed staff obtained her blood pressure weekly from 12/14/24 to 3/24/25, even though the 08/31/24 order was still active, and the resident still received the same medication. On 03/25/25 at 11:32 AM, Certified Medication Aide (CMA) S administered medications to R34 who took the pills whole without problems. On 03/25/25 at 02:10 PM, Administrative Nurse D verified the facility's consultant pharmacist had not notified her of the blood pressure not being monitored as ordered. The facility's undated Medication Administration, policy stated the contracted consultant pharmacist would review the elder's medication regimen monthly and document the findings and recommendations. The consultant pharmacist would communicate to the physician and those involved in the elder's care the findings, conclusions, and recommendations that result from monitoring the medication regimen. The facility's consultant pharmacist failed to notify the director of nursing or R34's physician of the lack of monitoring R34's blood pressure as the physician ordered to monitor the effectiveness of her medication, placing R34 at risk of receiving unnecessary medication.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to monitor Resident (R)34's blood pressure as the physician ordered to monitor the effectiveness of her medication. This deficient practice placed R34 at risk of receiving unnecessary medication. Findings included: - R34's Electronic Medical Record documented diagnoses of hypertension (HTN - elevated blood pressure), transient cerebral ischemic attack (TIA - temporary episode of inadequate blood supply to the brain), and anemia (inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented R34 received antidepressant (class of medications used to treat mood disorders), diuretic (medication to promote the formation and excretion of urine), and opioid (narcotic) medications. The Care Plan, dated 02/17/25, directed staff to consult with a pharmacist as needed, monitor, and report adverse reactions to medication therapy. The Physician Order, dated 08/31/24, directed staff to administer losartan (blood pressure lowering drug) 100 milligrams (mg) daily. The order stated to hold the drug if R34's systolic blood pressure (SB/P) was less than 100 mmHg (millimeters of mercury) or the diastolic blood pressure (DB/P) was less than 60 mmHg. R34's blood pressure documentation revealed staff obtained her blood pressure weekly from 12/14/24 to 3/24/25, even though the 08/31/24 order was still active, and the resident still received the same medication. On 03/25/25 at 11:32 AM, Certified Medication Aide (CMA) S administered medications to R34 who took the pills whole without problems. On 03/25/25 at 02:10 PM, Administrative Nurse D stated R34 switched physicians and the order from the previous physician was still in the computer. They plan to contact the current physician to verify if he wants to set parameters. She verified staff should have obtained blood pressure with the administration of losartan. The facility's undated Medication Administration, policy stated all medications would be administered as ordered by a physician in a safe and sanitary manner. Each elder's drug regimen would be free of unnecessary drugs, defined as: without adequate, recommended monitoring. The nursing staff would monitor the elder's response to medications by relevant lab values and clinical response. The facility failed to monitor R34's blood pressure as the physician ordered to monitor the effectiveness of her medication. This deficient practice placed R34 at risk of receiving unnecessary medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 39 residents. The sample included 13 residents. Based on observation, interview, and record review, the facility failed to remove expired medication from use and failed to date one insulin pen when opened. This deficient practice placed residents who may have received those medications at risk for ineffective medication. Findings included: - On 03/24/25 at 09:07 AM, observation of the one facility medication room revealed 14 bisacodyl (laxative) suppositories with an expiration date of November 2024 and a container of aspirin/diphenhydramine (pain relief/sleep aide) 500/25 milligrams (mg) tablets, expired December 2024. On 03/24/25 at 09:22 AM, the facility's nurse treatment cart contained an opened, undated glargine insulin pen. On 03/24/25 at 09:07 AM, Licensed Nurse (LN) G verified the medications in the medication room were expired and she disposed of them. On 03/24/25 at 09:22 AM, LN H verified staff should have dated the insulin pen when they opened it for use. On 03/26/25 at 07:50 AM, Administrative Staff D verified staff were to date insulin pens when opened. 03/26/25 at 08:22 AM, Administrative Staff D stated staff were to check for expiration dates when taking medications from the medication room to place on the cart for administration. The facility's undated Medication Expiration and Disposal policy stated the facility established a protocol for managing expired medications to prevent medication errors, ensure compliance with regulatory standards, and safeguard the health of residents. The facility would conduct a weekly audit of all medication inventories to identify that all medications have an expiration date, an opened-on date, and a use-by date based on manufacturer and pharmacy standards of practice. The policy stated nursing staff were responsible for checking expiration dates and use-by dates at the time of administration. The facility failed to remove expired medication from use and failed to date one insulin pen when opened. This deficient practice placed residents who may have received those medications at risk for ineffective medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 39 residents. Based on observation, interview, and record review the facility failed to provide the services of a full-time certified dietary manager for 39 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 03/24/25 at 09:00 AM, observation in the facility kitchen revealed three staff working, including Dietary Staff BB who stated she was the dietary manager. She stated she started about three months ago, and was not certified. Dietary Staff BB stated she had just started taking the classes for Certified Dietary Manager. On 03/26/25 at 02:32 PM, Administrative Staff A verified the facility's Dietary Manager was not certified. The facility Failed to provide a policy for Qualified Dietary Managers. The facility failed to provide the services of a full-time certified dietary manager for 39 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition.

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	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Home Inc	620 Second Avenue Concordia, KS 66901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility had a census of 39 residents. Based on observation, record review, and interview, the facility failed to maintain an infection monitoring surveillance plan and Enhanced Barrier Protection (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) as staff wore gown and gloves (PPE - gowns, face shields and/or eyeglasses/goggles, and gloves) in the hallway. This deficient practice placed the residents at risk for exposure to infectious processes. Findings included: - On 03/25/25 at 08:25 AM, Certified Nurse Aide (CNA) M wore a yellow protective gown and gloves while pushing a resident in a wheelchair to the dining room. CNA M then went to a closet next to the dining room area and opened it with the PPE on. CNA M stated she wore the gown in the hallway so that the surveyor would know what she looked like in one. CNA M then proceeded to remove the gown and gloves in the service hall next to the dining room. On 03/26/25 at 11:30 AM, Administrative Nurse D verified the infection tracking system had not been correctly implemented before January 2025. The facility staff recognized that the infection tracking had not been correctly followed, and since January 2025, they had established an infection tracking system. Administrative Nurse D reported that the information gathered from the implemented system is reviewed at the monthly Quality Assurance meetings. Administrative Nurse D stated CNA M had been educated on the use of PPE outside of resident rooms and should not wear the PPE in the hallways. The facility's Enhanced Barrier Precautions (EBP) policy dated 12/31/24, documented that the facility follows recommended guidance from the Centers for Disease Control to keep all residents from Healthcare Acquired Infections (HAI). EBPs are implemented as one intervention that this facility uses to reduce transmission of resistant organisms, which employ targeted PPE use during high-contact resident care activities. Staff will not wear the same gown and gloves for the care of more than one resident or reuse the gown and gloves for the same resident. Position a trash can inside the resident's room and near the exit for discarding PPE after removing it before exiting the room, or before providing care for another resident in the same room. The facility's Infection Prevention and Control Program, dated 05/11/23, documented that the facility has established and maintains 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 as per accepted national standards and guidelines. A system of surveillance is utilized for prevention, 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 a facility assessment and accepted national standards. The facility failed to ensure the disposal of PPE before leaving residents' rooms and to maintain an infection monitoring surveillance plan. This deficient practice placed the residents at risk of infectious disease processes.