DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Dore | TITLE: Administrator | (X6) DATE: 9/6/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1	F 578		

the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to accurately show the residents' correct code status in the resident's medical record when the code status did not match in all areas of the resident's medical record. This affected two of the 12 sampled residents (Residents #185 and #28). The facility census was 33.

Review of facility policy, Advance Directive, undated, showed:
-The facility will respect advance directives in accordance with state law;
-Upon admission of a resident to the facility, the social services designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive;
-Upon admission of a resident, the social services designee will inquire of the resident, and/or his/her family members, about the existence of any written advance directives;
-Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record under the advance directive tab.

1. Review of Resident #185's entry tracking minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 8/9/24, showed he/she entered from a short term general hospital stay.

Review of resident's baseline care plan, dated

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F 578	Continued From page 2	F 578		

8/12/24, showed:
-He/She was a do not resuscitate (DNR- no life saving measures) code status
-Diagnoses included: A fracture of lower end of left radius (long bone of the arm), respiratory failure, unsteadiness on feet, weakness, and chronic pain.

Review of physician's orders dated 7/1/24 to 8/31/24, showed he/she had a DNR code status.

Review of resident's paper medical record showed he/she had a green sheet that stated he/she was a full code.

During an interview on 8/13/24 at 1:17 P.M., Social Services director said:
-Resident was a full code;
-He/She saw that resident had wrong code status on his/her physician's orders and on their care plan; -He/She went in and changed the code status on resident's orders on 8/13/24 after learning they did not match.

During an interview on 8/14/24 at 9:30 A.M., Certified Nurse Aide (CNA) B said:
-He/She knew the code status by looking at the resident's paper chart and the stickers on resident's doors;
-A red sticker meant the resident was a DNR and a green sticker meant he/she wanted to be full code status which meant facility would initiate cardio-pulmonary-resuscitation (CPR);
-He/She would find a nurse if resident had green status since he/she was not CPR certified;

2. Review of Resident #28 Quarterly MDS dated 5/16/24 showed:
-BIMS of 15, indicated no cognitive loss

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F 578	Continued From page 3	F 578		

-Partial to maximum assistance of staff for ADLs.
-Diagnoses of Combined Congestive Heart Failure (the heart muscle weakens and enlarges, making it difficult for the heart to pump enough blood), Atrail Fibrillation, Depression, Hypertenstion (high blood pressure) and morbid Obesity (A disorder that involves having too much body fat, which increases the risk of health problems.) Obstructive Sleep Apnea.

Review of the resident's August Physician Orders showed a Code Status as DNR and dated 8/2/24.

Review of the resident's paper medical record showed a green FULL CODE paper in the front of the chart.

Review of the resident's electronic medical record showed:
-The admission checklist dated 2/8/24 was not completed.
-The outside the Hospital DNR paperwork in the admission packet was not signed or dated by the resident or the physician..

Observation and interview on 08/13/24 at 10:22 A.M. showed a green sticker on the resident's name plate. The resident said he/she had not changed his/her code status recently.

During an interview on 08/13/24 at 9:58 A.M. CNA A said:
- Green stickers on the name plate meant the resident was a full code, and red meant DNR.
-If the resident had nothing on their name plate the sticker may have fallen off.
-All residents should have a red or green indicator on their name plate.
-The other place he/she would look for code

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F 578	Continued From page 4	F 578		

status was in the paper chart, on top when the chart is opened.

During an interview on 8/13/24 at 9:59 AM CNA B said:
-The Resident's chart had a paper in front when opened for code status.
-Resident #28 has a green sticker on his/her nameplate and would be a full code.

During an interview on 8/13/24 at 10:30 AM the SSD said:
-She was responsible for code status paperwork and signs.
-Resident #28 was a full code, not a DNR.
-She was not aware there was a physician's order for DNR status.

During an interview on 8/13/24 at 10:42 AM Licensed Practical Nurse A said:
-He/She would have to look at the resident's chart for code status.
-Green dots on name plates mean full code and red dots mean DNR, it was the same for the paper in the resident's chart.
-SSD would get the DNR signed and give it to him/her.
-He/She would notify the physician, get the order and place it in the computer.

During an interview on 8/14/24 at 1:03 P.M., Administrator said he/she expected the code status to be the same on physician's orders, electronic records, and paper chart with everything matching.

During an interview on 8/14/24 at 3:19 P.M., Director of Nursing said:
-The nurse puts the orders in the electronic

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F 578	Continued From page 5 records for advance directives and code status; -The social service staff was responsible for completing the code status paperwork; -A resident's code status should match in all places of their medical record; -Staff should be knowledgeable of each resident's code status; -He/She was aware that their was two residents code status that did not match in all areas of the resident's record.	F 578		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.	F 607		

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F 607	Continued From page 6	F 607		

§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to follow the written policy to check the Nurses Aide (NA) registry prior to hire for three of 5 sampled staff members. The facility census was 33.

Review of the undated abuse and neglect policy showed:
Before a prospective employee is allowed to work with the residents, a complete background check will be completed;
The facility will not employ an individual who has a finding entered on the state nurse aide registry.

1. Review of Dietary Aide (DA) B personnel file showed the following:
- He/She was hired 6/22/23 to work as a DA in the kitchen;
- No completed NA registry check.

2. Review of Nurses Aide (NA) A's personnel fie showed the following:
- He/She was hired 7/6/23 to work as an NA;
- No completed NA registry check.

3. Review of the Director of Nurses (DON) personal file showed the following:
- He/she was hired 4/17/23 to work as the DON;
- No completed NA registry check.

During an interview on 8/14/24 at 8:27 A.M. the administrator said:
- The Business Office Manager (BOM) completes

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F 607	Continued From page 7 the NA registry checks prior to a staff member being hired; - All staff regardless if they are nursing or not are checked on the NA registry. During a follow up interview on 8/14/24 at 9:18 A.M. the Administrator said: - She expected the NA checks to be completed and in the the staff's personnel files; - She expected the NA checks to be completed prior to the staff members first day of employment.	F 607		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623		

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F 623	Continued From page 8	F 623		

(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

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F 623	Continued From page 9	F 623		

the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review the facility failed to document and provide two residents (Resident #13 and #14), with written notice of transfer when the residents were transferred to local hospitals. the facility census was 33.

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F 623	Continued From page 10	F 623		

The facility staff did not provide a policy regarding transfers.

1. Review of Resident #13's quarterly Minimum Data Set, (MDS, a federally mandated assessment completed by the facility staff), dated 8/4/24 showed:
- The resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment;
- He/She required substantial assistance to get dressed, use the toilet and to bathe;
- Diagnoses included: Bipolar disorder (mood swings that range from depression to very happy), Atrial Fibrillation (a disorder in which the heart does not beat correctly), epilepsy (seizure disorder), and Chronic Obstructive Pulmonary Disease (COPD).

During an interview on 8/12/24 at 9:55 A.M. the resident said:
He/She was in the hospital after he/she fell around the beginning of the year;
- The Facility staff did not provide him/her with written notice regarding the transfer before he/she went to the hospital.

Review of the resident's record showed the following:
- He/She returned from the hospital on 1/4/24 after being hospitalized after he/she fell and broke his/her hip;
- There was no documentation of a transfer form in the resident's record.

2. Review of Resident #14's quarterly MDS dated 6/26/24 showed:
- He/She had a BIMS score of 11, indicating moderate cognitive impairment;

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F 623	Continued From page 11	F 623		

- He/She was dependent on the staff to use the toilet, get dressed and to shower;
- Diagnoses included: Stroke, anxiety, pneumonia (an infection of the lungs), and frequent falls.

Review of the resident's record showed the following:
- Licensed Practical Nurse (LPN) A documented on 7/5/24 at 3:23 P.M. he/she was called to the resident's room by staff;
- The resident had difficulty breathing with his/her oxygen on, and the resident was shaking;
- The resident blood pressure was 170/120 (high), pulse was 150 beats per minute (high), respirations were 28 per minute (high) and the resident oxygen saturation was 76% while receiving 4 liters of oxygen (low);
- The resident was sent to the hospital emergency room for further evaluation;
- The resident was admitted to the hospital for pneumonia;
- There was no transfer form documented in the resident's record.

3. During an interview on 8/13/24 at 11:25 A.M. the Social Services Director said:
- Normally he/she completed the transfer notices, however, if the resident was transferred on the weekend, or after hours, the nurse would complete the transfer form;
- Sometimes the transfer form not completed;
- Resident #13 and #14 should have had a transfer form completed prior to going to the hospital.

During an interview on 8/13/24 at 12:56 P.M. the Administrator said:
- Resident #13 and #14 should have a transfer form completed and sent with each

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F 623	Continued From page 12 hospitalization; - The transfer form should be provided to the resident and the guardian in a language that can be understood; - She expected the transfer form to be documented in the resident's chart.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced	F 625		

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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 625	Continued From page 13	F 625		

by:
Based on interviews and record review the facility failed to document and provide two residents (Resident #13 and #14), with a notice of bed hold policy when the residents were transferred to local hospitals. The facility census was 33.

Review of the undated bed hold policy showed:
- All residents and guardians will be notified of bed hold guidelines;
- Notification will be given upon admission and at the time of transfer to the hospital.

1. Review of Resident #13's quarterly Minimum Data Set, (MDS, a federally mandated assessment completed by the facility staff), dated 8/4/24 showed:
- The resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment;
- He/She required substantial assistance to get dressed, use the toilet and to bathe;
- Diagnoses included: Bipolar disorder (mood swings that range from depression to very happy), Atrial Fibrillation (a disorder in which the heart does not beat correctly), epilepsy (seizure disorder), and Chronic Obstructive Pulmonary Disease (COPD).

During an interview on 8/12/24 at 9:55 A.M. the resident said:
He/She was in the hospital after he/she fell around the beginning of the year;
- The facility staff did not give him/her a bed-hold policy form before he/she went to the hospital.

Review of the resident's record showed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 625	Continued From page 14	F 625		

- He/She returned from the hospital on 1/4/24 after being hospitalized after he/she fell and broke his/her hip;
- There was no documentation of a bed-hold policy form in the resident's record.

2. Review of Resident #14's quarterly MDS dated 6/26/24 showed:
- He/She had a BIMS score of 11, indicating moderate cognitive impairment;
- He/She was dependent on the staff to use the toilet, get dressed and to shower;
- Diagnoses included: Stroke, anxiety, pneumonia (an infection of the lungs), and frequent falls.

Review of the resident's record showed the following:
- Licensed Practical Nurse (LPN) A documented on 7/5/24 at 3:23 P.M. he/she was called to the resident's room by staff;
- The resident had difficulty breathing with his/her oxygen on, and the resident was shaking;
- The resident blood pressure was 170/120 (high), pulse was 150 beats per minute (high), respirations were 28 per minute (high) and the resident oxygen saturation was 76% while receiving 4 liters of oxygen (low);
- The resident was sent to the hospital emergency room for further evaluation;
- The resident was admitted to the hospital for pneumonia;
- There was no bed-hold policy form documented in the resident's record.

3. During an interview on 8/13/24 at 11:25 A.M. the Social Services Director said:
- The bed-hold policy was signed with each resident upon admission if they want their bed held or not, but not completed again when the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 15 resident transfers transferring to the hospital; - He/She did not know why bed-hold policy was not completed with each hospitalization. During an interview on 8/13/24 at 12:56 P.M. the Administrator said: - Resident #13 and #14 should have bed-hold policy form completed and sent with them with each hospitalization; - The bed-hold policy form should be provided to the resident and the guardian in language that can be understood; - She expected the bed-hold policy form to be documented in the resident's chart.	F 625		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		

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F 656	Continued From page 16	F 656		

rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure residents had complete, accurate and individualized care plans, to address the specific needs of the residents, for three of the 12 sampled residents (Residents #2, #20 #30,). The census was 33.

The facility did not provide a policy on Care Plans.

1. Review of Resident #30's Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 7/30/24 showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 656	Continued From page 17	F 656		

-Brief Interview of mental status (BIMS) of 15, indicated no cognitive loss
-Set up assistance of staff for Activities of Daily Living (ADLs: activities done in a day to care for oneself)
-Diagnoses of : Chronic Obstructive Pulmonary Disease (COPD: A lung disease that causes breathing problems and restricted airflow.) Chronic Atrial Fibrillation (Afib: a heart condition that causes rapid, irregular heart beats) Post Traumatic Stress Disorder (PTSD:A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event.) Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Anxiety (a feeling of dread, fear, or uneasiness)

Review of the resident's Initial, undated, Care Plan, showed- no care plan for the diagnosis of PTSD, use of Oxygen, use of Continuous Positive Airway Pressure(CPAP) (A machine that uses mild air pressure to keep breathing airways open while you sleep) or a diagnosis of COPD.

Review of the physician's order sheet for August 2024 showed:
-Oxygen (O2) 2-5 Liters per minute (LPM) per nasal cannula, continuous every shift
-No order for the c pap

Observation on 08/13/24 at 8:44 AM showed:
-The resident was sitting up on his/her bed with oxygen on at 3 liters per minute per nasal cannula.
-Respirations are forceful and shallow
-He/she cried at times
-He/she ran hands through his/her hair over and over

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 656	Continued From page 18 -His/her hands were shaking During an interview with the resident on 8/13/24 at 8:45 A.M. the resident said: -He/she was very short of breath -Staff assist him/her in putting on the cpap machine at night. -He/she wears O2 at all times -He/She does have a diagnosis of PTSD -He/she has nightmares at times -He/she felt as if his/her anxiety and depression were through the roof -He/She does not see a professional such as a Psychologist, Counselor or Psychiatrist. -The nurses will sit with him/her sometimes when he/she feels like he/she needs to talk. During an interview on 8/13/24 at 9:02 A.M. showed Certified Nurse Aide (CNA) D said: -He/she was not aware Resident #30 had PTSD. -He/she was aware the resident wore O2 -Information for the residents could be found in the care plan 2. Review of Resident #2's Quarterly MDS, dated 5/13/24, showed: -He/She is moderately cognitive impaired; -He/She had clear speech and was able to make-self understood and understand others; -He/She was dependent on a wheelchair and walker for mobility; -He/She needed partial to moderate assistance with toileting, personal hygiene, rolling left and right and sit to lying; -He/She needed substantial/maximal assistance with moving from lying to sitting on side of bed; -Diagnoses included: Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the	F 656		

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SUNSET HOME	1201 S POLK MAYSVILLE, MO 64469

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F 656	Continued From page 19	F 656		

nerves), high blood pressure, chronic pain, tendency to fall, reduced mobility, need for assistance with personal care, history of falling, generalized muscle weakness, unsteadiness on feet, and cognitive communication deficit (a condition affecting a person's ability to think, learn, remember, use judgement, and make decisions).

Review of Resident #2's Annual assessment, dated 11/11/23, showed:
-It was very important for the resident to choose what clothes to wear, have snacks, take care of personal belongings, choose a bedtime, have family or close friend involved in discussions about care,
-Activity preferences included: Having access to books, newspapers, magazines to read, listen to music, be around animals as pets, keep up with the news, do things with groups of people, do favorite activities, go outside and get fresh air, and participate in religious services.

Review of the residents care plan, dated 7/5/24, showed his/her care plan did not address the resident's activity preferences.

During an interview on 8/12/24 at 10:38 A.M. the resident said:
-He/She enjoyed playing bingo and jeopardy;
-He/She did not think the facility had enough activities to interest him/her;
-He/She would like to see the facility offer book reviews.

Review of the electronic resident medical record showed he/she had no activity notes documented in progress notes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 656	Continued From page 20	F 656		

3. Review of Resident #13's Quarterly MDS, dated 8/4/24, showed:
-His/Her cognition was intact;
-He/She had clear speech;
-He/She was able to make self-understood and understand others;
-He/She was dependent on a wheelchair for mobility;
-He/She required substantial assistance with moving from lying to sitting, toileting, and bathing;
-He/She required partial/moderate assistance with personal hygiene, rolling left and right, sit to stand transfers, chair to bed transfers;
-Diagnoses included: muscle weakness, anxiety, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), polyneuropathy (a decreased ability to move and feel sensation because of nerve damage), low back pain, and edema (a condition when tiny blood vessels in the body leak fluid).

Review of Resident #13's Annual MDS, dated 11/2/23, showed:
-He/She found it very important to go outside to get fresh air when weather was good, important to do his/her favorite activities, keep up with the news, and to listen to music he/she liked;
-Care area's triggered included activities.

Review of the care plan, dated 11/12/24 showed:
-He/She had potential for social isolation due to lack of interest;
-Allow him/her the opportunity to voice his/her feeling & fears;
-Encourage him/her to attend activities which improve self esteem;
-Introduce him/her to other residents;
-Staff to make contact on the 1st & 2nd shift daily;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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SUNSET HOME	1201 S POLK MAYSVILLE, MO 64469

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F 656	Continued From page 21	F 656		

-To the extent possible, offer his/her favorite activities.

During an interview on 8/13/24 at 1:11 P.M., Resident said:
-He/She felt activities were never geared towards men;
-All activity groups were just women's groups;

Review of resident's electronic medical record showed he/she had no activity notes documented in progress notes.

4. Review of Resident #20's Quarterly MDS, dated 6/25/24, showed:
-He/She had moderate cognitive impairment;
-He/She had clear speech, was able to make self-understood and understand others;
-He/She was dependent on a wheelchair for mobility;
-He/She required set up or clean up assistance with eating, personal hygiene, and bathing;
-Diagnoses included: Multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), depression, asthma, cellulitis of right lower limb (a skin infection caused by bacteria), pain, polyneuropathy, generalized muscle weakness, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet).

Review of resident's Annual MDS, dated 8/23/23, showed:
-It was very important to him/her to have books, newspapers, and magazines to read, listen to music he/she liked, keep up with the news, to do things with groups of people, to participate in his/her favorite activities, and to go outside to get fresh air when weather was good.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 656	Continued From page 22	F 656		

-Care area's triggered included activities.

Review of care plan, dated 6/28/24, showed he/she had no activity preferences care planned.

During an interview on 8/14/24 at 12:23 P.M., Resident said:
-The facility did not have much for activities to do here;
-There was not enough staff to help offer resident individual activities;
-There was not enough activities that met his/her interest levels;
-He/She liked to have outside activities;
-He/She liked to play baseball and kickball;
-Activity Director sometimes came around and invited him/her to activities;

Review of the resident's electronic medical record showed he/she had no activity notes documented in progress notes.

During an interview on 8/13/24 at 1:13 P.M., the Activity Director said:
-He/She completed activity assessments with residents upon admission and annually;
-He/She did not track activities that he/she did with each resident;
-He/She did offer one on one activities like coloring, playing card games like UNO or phase 10;
-He/She did not offer specific activities geared towards men but all activities except manicures were inclusive to men;
-He/She offered bingo, exercise, and sweet treats;
-He/She offered one on one activities by putting a music on in resident's rooms;
-Activity calendar was posted on bulletin boards

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	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 656	Continued From page 23 on each hall for residents to see; -He/She did not have a way for resident's who were in their rooms or bed bound to see activities offered each day; During an interview on 8/14/24 at 1:03 P.M., the Administrator said: -He/She expected activity preferences to be care planned when a resident had special interest or an activity that he/she liked. -He/She expected PTSD to be care planned. During an interview on 8/14/24 at 1:21 P.M., the Director of Nursing said: -He/She expected care plans to be updated with any changes and quarterly with the MDS; -He/She expected resident activity preferences to be care planned. -PTSD should be care planned.	F 656		
F 657 SS=E	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	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 657	Continued From page 24	F 657		

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:
Based on observations, interview, and record review, the facility failed to ensure staff developed and updated care plans consistent with resident's specific conditions and needs which affected one of 12 sampled residents (Resident #2). Additionally, the facility failed to conduct quarterly care plan meetings to discuss the residents plan of care. This deficient practice affected two of 12 sampled residents, (Resident #13 and #17). The facility census was 33.

Review of the facility policy, MDS and Care Planning guidelines, dated September 2013, showed:
-It was the policy of facility to use the most current guidelines for Centers for Medicare and Medicaid services (CMS) regarding the Minimum Data Set (MDS) Resident assessment Instrument manual, any published interim RAI manual errata documents, and applicable federal guidelines as the authoritative guide for completion of MDS, CAAs, and resident care planning.

1. Review of Resident #2's Quarterly minimum data set (MDS), A federally mandated assessment tool completed by facility staff, dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 25	F 657		

5/13/24, showed:
-He/She had moderate cognitive impairment;
-He/She had clear speech and was able to make-self understood and understand others;
-He/She was dependent on a wheelchair and walker for mobility:
-He/She required set up or clean up assistance with eating;
-He/She was on a mechanically altered diet;
-Diagnoses included: Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), high blood pressure, chronic pain, tendency to fall, reduced mobility, need for assistance with personal care, history of falling, generalized muscle weakness, and unsteadiness on feet.

Review of the resident's care plan, dated 5/14/24, showed:
-He/She required special utensils at meals related to Parkinson's and was a potential for weight loss;
-He/She was to use built up silverware with meals;
-Care plan did not reflect discontinued use of weighted utensils.

Review of physician's orders dated 7/1/24 to 8/31/24, showed:
-He/She was on a regular diet;
-He/She had no orders for weighted utensils.

Review of discontinued physician's orders showed:
-On 2/27/23, he/she had an order to start regular diet with built up silverware;
-On 8/7/23, he/she had orders for built up silverware to be discontinued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 657	Continued From page 26	F 657		

Review of occupational therapy notes showed:
-On 6/21/24, He/She was independent with eating with no assistance from helper.

Observation at lunch on 8/12/24 at 1:35 P.M. showed resident was using plastic silverware and did not have weighted utensils.

Observation at breakfast on 8/14/24 at 8:02 A.M. showed resident was using regular silverware and did not use weighted utensils.

During an interview on 8/14/24 at 8:04 A.M., Resident said he/she did not use weighted utensils anymore.

During an interview on 8/14/24 at 8:12 A.M., CNA C said:
-He/She did not think resident used weighted utensils anymore;
-Resident use to have weighted utensils with his/her meals.

During an interview on 8/14/24 at 8:50 A.M., Licensed Practical Nurse (LPN) A said:
-Resident used to use weighted silverware;
-He/She was not sure if resident still had orders for weighted utensils;
-He/She knew occupational therapy had originally wrote resident's orders for weighted utensils.

During an interview on 8/14/24 at 1:03 P.M., the Administrator said:
-He/She expected that the resident's care plan would be updated when a resident's occupational therapy orders for weighted spoon was discontinued.
-He/She expected resident's care plans to be updated with changes, after an incident occurred,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 657	Continued From page 27	F 657		

and quarterly.

During an interview on 8/14/24 at 1:21 P.M., Director of Nursing (DON) said:
-He/She expected a resident's care plan to be updated when his/her weighted spoon orders were discontinued;
-Care plans should be updated quarterly and as needed with any resident or order changes;
-He/She was not aware that he/she was responsible for updating care plans when he/she was hired.

2. Review of Resident #13's quarterly Minimum Data Set, (MDS, a federally mandated assessment completed by the facility staff), dated 8/4/24 showed:
- The resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment;
- He/She required substantial assistance to get dressed, use the toilet and to bathe;
- Diagnoses included: Bipolar disorder (mood swings that range from depression to very happy), Atrial Fibrillation (a disorder in which the heart does not beat correctly), epilepsy (seizure disorder), and Chronic Obstructive Pulmonary Disease (COPD).

Review of there resident's care plan showed:
- 6/13/24 the resident received anti psychotic medications (medications to treat bipolar disorder);
- 11/1/17 the resident had a guardian and the guardian will be encouraged to attend all care plan meetings;
- 11/1/17 encourage the resident to participate in activities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 657	Continued From page 28	F 657		

During an interview on 8/12/24 at 9:50 A.M. the resident said:
- He/She had never been invited to a care plan meeting;
- He/She would like to know what was going on for his/her plan of care;
- He/She would like to be invited and participate in his/her plan of care.

3. Review of Resident #17's quarterly MDS dated 6/7/24 showed:
- He/She had a BIMS score of 3, indicating severe cognitive impairment;
- He/She required stand by assistance to get dressed and shower;
- Diagnoses included: Bipolar with psychotic features, vascular dementia (impairment of reason and memory sustained after a stroke), and Diabetes Mellitus Type II (a disorder in which the body does not process blood sugar properly).

Review of the resident's care plan showed:
- 6/13/24 the resident receives medication to treat his/her bipolar disorder;
- 12/16/19 the resident had a guardian and invite the guardian to care plan meetings and involve them with the plan of care changes.

During an interview on 8/12/24 at 8:51 A.M. the resident said:
- He/She did not know what a care plan was;
- He/She would like to be a part of his/her care planning and would like to be invited to his/her care plan meeting.

4. During an interview on 8/13/24 at 9:18 A.M. the DON said:
- He/She was in charge of writing the resident's care plans;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 657	Continued From page 29 - He/She was in charge of coordinating care plan meetings; - He/She was aware that each resident should have a care plan meeting quarterly; - He/She was employed at the facility in April of 2023 and had not held a care plan meeting since his/her time of hire.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to provide meaningful activities for five of 12 sampled residents (Resident #17, #21, #2, #13, #20). The facility census was 33. Review of the undated activity policy said: - Activities services will plan, organize and carry out a program of activities to meet the individual needs of the residents; - The Activities Director (AD) plans and organizes individual activities and group activities; - A calendar of events will be posted on the activity bulletin board; - All staff are responsible to assist residents to the	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 679	Continued From page 30	F 679		

activity
- The AD will develop an activity calendar to include a wide variety of activities to include spiritual, physical, emotional, cognitive, sensory, recreational, and work service related activities;
- Activities will be planned for men and women and large and small groups.

1. Review of Resident #17's quarterly Minimum Data Set (MDS, a federally mandated assessment completed by the facility staff), dated 6/7/24 showed:
- He/She had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment;
- He/She required stand by assistance to get dressed and shower;
- Diagnoses included: Bipolar with psychotic features, vascular dementia (impairment of reason and memory sustained after a stroke), and Diabetes Mellitus Type II (a disorder in which the body does not process blood sugar properly).

Review of the resident's activity care plan dated 3/14/19 showed:
- The resident enjoyed watching television in his/her room with his/her parent;
- The staff were supposed to encourage him/her to attend activities which improve self esteem;
- Allow the resident to voice his/her feelings and fears.

During an interview on 8/12/24 at 8:47 A.M. the resident said:
- He/She did not participate in activities because nothing interests him/her that is offered;
- If they did different activities he/she would participate more;
- The staff do not invite him/her to activities;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 31	F 679		

- He/She would like to be invited to activities;
- He/She did not know what activities there were to choose from;
- It made him/her feel bad no being invited to participate in activities.

Observation on 8/13/24 at 11:00 A.M. showed
- No activity calendar in the common area or in the resident's room.

Observation and interview on 8/14/24 at 10:00 A.M. showed:
- The Activity Director (AD) setting up Bingo in the dining room;
- The resident was not in the dining room;
- At 10:01 the AD starts Bingo;
- At 10:07 the resident was observed lying in his/her bed watching television;
- At 10:10 A.M. the resident said he/she was not told Bingo was in the dining room, the resident got out of bed and walked to the dining room to attend the activity;
- At 10:20 A.M. The activity concluded and residents left the dining room;
- The resident returned to his/her bed;
- The resident said he/she was sad he/she missed most of Bingo.

During an interview on 8/14/24 at 10:10 A.M. Certified Medication Technician (CMT) A said:
- The AD usually assisted the resident to the activities;
- If the AD needed assistance with a resident, he/she told the staff and they helped get residents to the activity.

2. Review of Resident #21's quarterly MDS dated 7/27/24 showed:
- BIMS score of 8, indicating moderate cognitive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 32	F 679		

impairment;
- He/She required assistance with transfers, bathing, toilet care, and getting dressed;
- Diagnoses included: Bipolar disorder, weakness and psychosis.

Review of the activity care plan dated 4/30/24 showed:
- The resident was able to be involved in recreational and social activities that interest him/her;
- He/She rarely participated in activities;
- The staff were supposed to encourage the resident to participate in activities;
- The staff were supposed to inform the resident of upcoming activities.

During an interview on 8/12/24 at 9:14 A.M. the resident said:
- He/She enjoyed playing Bingo;
- He/She would like to participate in other activities;
- He/She would like to have more music activities.
3. Review of Resident #2's Quarterly MDS., dated 5/13/24, showed:
-He/She had moderate cognitive impairment;
-He/She had clear speech and was able to make-self understood and understand others;
-He/She was dependent on a wheelchair and walker for mobility;
-He/She needed partial to moderate assistance with toileting, personal hygiene, rolling left and right and sit to lying;
-He/She needed substantial/maximal assistance with moving from lying to sitting on side of bed;
-Diagnoses included: Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), high blood pressure, chronic pain,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 33	F 679		

tendency to fall, reduced mobility, need for assistance with personal care, history of falling, generalized muscle weakness, unsteadiness on feet, and cognitive communication deficit (a condition affecting a person's ability to think, learn, remember, use judgement, and make decisions).

Review of Resident #2's Annual MDS, dated 11/11/23, showed:
-It was very important to choose what clothes to wear, have snacks, take care of personal belongings, choose bedtime, have family or close friend involved in discussions about care,
-Activity preferences included have books, newspapers, magazines to read, listen to music, be around animals as pets, keep up with the news, do things with groups of people, do favorite activities, go outside and get fresh air, participate in religious services.

Review of care plan, dated 7/5/24, showed:
-His/Her care plan did not address resident's activity preferences.

Review of the residents electronic medical record showed:
-He/She had no activity notes documented in progress notes.

During an interview on 8/12/24 at 10:38 A.M. Resident #2 said:
-He/She enjoyed playing bingo and jeopardy;
-He/She did not think the facility had enough activities to interest him/her;
-He/She would like to see the facility offer book reviews;
-He/She did not have any activity calendar available in his/her room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 34	F 679		

Observation on 8/12/24 at 10:38 A.M. showed no activity calendar available in resident's room.

Review of the facility activity calendar showed:
-8/12/24 at 10:00 A.M. bingo was scheduled;
-8/12/24 at 2:00 P.M. spay day was scheduled;
-8/13/24 at 10:00 A.M. exercise was scheduled;
-8/13/24 at 2:00 P.M. manicures were scheduled;
-8/14/24 at 10:00 A.M. bingo was scheduled.

Observation on 8/12/24 at 10:00 A.M. showed no activities offered.

Observation on 8/12/24 at 2:00 P.M. showed no activities offered.

Observation on 8/13/24 at 2:00 P.M. showed no activities offered.

Observation on 8/14/24 at 9:49 A.M., showed:
-Activity Director reminded resident of upcoming activity of bingo at 10:00 A.M.;
-Resident observed wheeling out of his/her room to go towards end of hall to participate in Bingo activity.

Observation on 8/14/24 at 10:03 A.M. showed resident engaged in activity of bingo in south dining room.

4. Review of Resident #13's Quarterly MDS, dated 8/4/24, showed:
-His/Her cognition was intact;
-He/She had clear speech;
-He/She was able to make self-understood and understand others;
-He/She was dependent on a wheelchair for mobility;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 35 -He/She required substantial assistance with moving from lying to sitting, toileting, and bathing; -He/She required partial/moderate assistance with personal hygiene, rolling left and right, sit to stand transfers, chair to bed transfers; -Diagnoses included: Muscle weakness, anxiety, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), polyneuropathy (a decreased ability to move and feel sensation because of nerve damage), low back pain, and edema (a condition when tiny blood vessels in the body leak fluid). Review of Resident #13's Annual MDS, dated 11/2/23, showed: -He/She found it very important to go outside to get fresh air when weather was good, important to do his/her favorite activities, keep up with the news, and to listen to music he/she liked; -Care area's triggered included activities. Review of care plan, dated 11/12/24 showed: -He/She had potential for social isolation due to lack of interest; -Allow him/her the opportunity to voice his/her feeling & fears; -Encourage him/her to attend activities which improve self esteem; -Introduce him/her to other residents; -Staff to make contact on the 1st & 2nd shift daily; -To the extent possible, offer his/her favorite activities. During an interview on 8/13/24 at 1:11 P.M., Resident said: -He/She felt activities were never geared towards men; -All activity groups were more women's groups;	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 36	F 679		

-He/She was made aware of activities by looking at white board in hallway;
-He/She did not have access to an activity schedule in his/her room.

Review of facility activity calendar showed:
-8/12/24 at 10:00 A.M. bingo was scheduled;
-8/12/24 at 2:00 P.M. spay day was scheduled;
-8/13/24 at 10:00 A.M. exercise was scheduled;
-8/13/24 at 2:00 P.M. manicures were scheduled;
-8/14/24 at 10:00 A.M. bingo was scheduled.

Observation on 8/12/24 at 10:00 A.M. showed no activities offered.

Observation on 8/12/24 at 2:00 P.M. showed no activities offered.

Observation on 8/13/24 at 2:00 P.M. showed no activities offered.

Observation on 8/14/24 at 9:49 A.M. showed Activity Director going to resident room to invite to bingo.

Observation on 8/14/24 at 10:01 A.M. showed resident was in dining room but did not participate in bingo.

5. Review of Resident #20's quarterly MDS, dated 6/25/24, showed:
-He/She had moderate cognitive impairment;
-He/She had clear speech, was able to make self-understood and understand others;
-He/She was dependent on a wheelchair for mobility;
-He/She required set up or clean up assistance with eating, personal hygiene, and bathing;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 37	F 679		

-Diagnoses included: Multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), depression, asthma, cellulitis of right lower limb (a skin infection caused by bacteria), pain, polyneuropathy, generalized muscle weakness, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet).

Review of Resident #20's Annual MDS, dated 8/23/23, showed:
-It was very important to him/her to have books, newspapers, and magazines to read, listen to music he/she liked, keep up with the news, to do things with groups of people, to participate in his/her favorite activities, and to go outside to get fresh air when weather was good.
-Care area's triggered included activities.

Review of care plan, dated 6/28/24, showed:
-He/She had no activity preferences care planned.

Review of facility activity calendar showed:
-8/12/24 at 10:00 A.M. bingo was scheduled;
-8/12/24 at 2:00 P.M. spay day was scheduled;
-8/13/24 at 10:00 A.M. exercise was scheduled;
-8/13/24 at 2:00 P.M. manicures were scheduled;
-8/14/24 at 10:00 A.M. bingo was scheduled.

Observation on 8/12/24 at 10:00 A.M. showed no activities offered;

Observation on 8/12/24 at 2:00 P.M. showed no activities offered;

Observation on 8/14/24 at 9:49 A.M. showed Activity Director going to resident room to invite to bingo.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 38	F 679		

Observation on 8/14/24 at 10:01 A.M. showed resident participated in bingo.

During an interview on 8/14/24 at 12:23 P.M., Resident said:
-The facility did not have much for activities to do here;
-There was not enough staff to help offer resident individual activities;
-There was not enough activities that met his/her interest levels;
-He/She liked to have outside activities;
-He/She liked to play baseball and kickball;
-Activity Director sometimes came around and invited him/her to activities;

6. During an interview on 8/13/24 at 1:13 P.M., Activity Director said:
-He/She completed activity assessments with residents upon admission and annually;
-He/She did not track activities that he/she did with each resident;
-He/She did offer one on one activities like coloring, playing card games like UNO or phase 10;
-He/She did not offer specific activities geared towards men but all activities except manicures were inclusive to men;
-He/She offered bingo, exercise, and sweet treats;
-He/She offered one on one activities by putting a music cd on in those resident's rooms;
-Activity calendar was posted on bulletin boards on each hall for residents to see;
-He/She did not have a way for resident's who were in their rooms or bed bound to see activities offered each day;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 679	Continued From page 39 During an interview on 8/14/24 at 8:14 A.M., Certified Nurse Aide (CNA) C said: -Activity Director takes residents to south hall for activities; -He/She was aware of activities of bingo and exercise occurring regularly; -Activity director offered activities 90% of time as scheduled. During an interview on 8/14/24 at 9:30 A.M., CNA B said: -Facility offered ice cream days, popcorn, movies, fingernail painting, and fake tattoos; -Facility offered a lot of bingo; -Residents are aware of activities by the activity calendar in hallway or activity director goes through halls to remind residents. During an interview on 8/14/24 at 10:29 A.M. the Director of Nursing (DON) said: - She would expect more activities to be completed than currently occur; - The AD had several other tasks assigned to him/her and was not able to complete more activities; - She would expect the large activity calendars on the wall to be up to date; - She would expect an activity calendar to be provided to each resident; - She expected all staff to help resident to activities; - She would expect all residents to be invited to activities.	F 679		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 695	Continued From page 40	F 695		

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:
Based on observation, record review, and interview, the facility failed to ensure staff obtained and followed complete and accurate physician orders for the administration of continuous positive airway pressure (CPAP: a type of ventilator that uses mild air pressure to keep breathing airways open while you sleep) for one resident . Additionally, the facility failed to label, date and clean the CPAP machines for 2 residents (Resident #30 and Resident #28) and failed to label and date open containers of distilled water for use in the CPAP machines for one resident (Resident #28) out of 12 sampled residents. The facility census was 33.

Review of the undated facility provided policy on Oxygen Equipment Cleaning Guidelines showed:
-Oxygen equipment will be cleaned to ensure safety in handling and administering oxygen.
-Connectors must be cleaned after each resident use.

Review of the undated facility provided policy CPAP Administration showed:
-Check the physician orders for pressure setting and method of administration;
-Fill the humidifier with distilled water to appropriate level;
-Tubing should be cleaned weekly, the mask and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 695	Continued From page 41	F 695		

nasal pillows connection wiped daily, clean the water holding tank with a damp cloth and mild soap weekly. For disinfecting the holding tank, use vinegar and water , let set for 30 minutes, rinse thoroughly and air dry.

Review of the ResMed Manufacturer's guidelines for cleaning CPAP machines showed:
-Clean the mask every day, or after each use.
1. Disassemble the mask components.
2. Thoroughly hand-wash the separated mask components by gently rubbing in warm water with mild detergent.
3. Rinse all the components well.
4. Allow to air dry out of direct sunlight and/or heat.
-Clean the device weekly as described.
1. Wash the water tub and air tubing in warm water using only mild detergent.
2. Rinse the water tub and air tubing thoroughly and allow to dry out of direct sunlight and/or heat.
3. Wipe the exterior of the device with a dry cloth.

1. Review of Resident #30 Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 7/30/24 showed:
-Brief Interview of mental status (BIMS) of 15, indicated no cognitive loss;
-Set up assistance of staff for Activities of Daily Living (ADLs: activities done in a day to care for oneself);
-Diagnoses of : Chronic Obstructive Pulmonary Disease (COPD: A lung disease that causes breathing problems and restricted airflow.)Obstructive Sleep Apnea (Intermittent airflow blockage during sleep caused by partial or complete collapse of the airway) Chronic Atrial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 695	Continued From page 42	F 695		

Fibrillation (Afib: a heart condition that causes rapid, irregular heart beats) Post Traumatic Stress Disorder (PTSD:A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event.) Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Anxiety (a feeling of dread, fear, or uneasiness)

Review of the Resident's Care Plan showed no care plan for the use of the CPAP machine.

Review of the Resident's physician orders for August 2024 showed:
-No order for the use of the CPAP machine.
-No orders for cleaning/changing tubing/masks.

Observation on 08/12/24 at 9:52 A.M. showed:
-Resident lying in bed.
-Large gift bag sitting on the floor at beside.
-CPAP mask was in the large gift bag lying on top of a purse.
-Condensation in the tubing to the mask.

Observation on 08/13/24 at 8:44 AM showed:
-He/She had complaints of difficulty breathing.
-His/Her CPAP was lying on top of a purse, in a large shopping bag at bedside.

During an interview on 8/13/24 at 8:46 A.M. the resident said:
-He/She puts the mask on at night .
- Staff had cleaned the machine and tubing before, but not daily.

2. Review of Resident #28 Quarterly MDS, dated 5/16/24., showed:
-BIMS of 15, indicated no cognitive loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 695	Continued From page 43	F 695		

-Partial to maximum assistance of staff for ADLs.
-Diagnoses of: Combined Congestive Heart Failure (the heart muscle weakens and enlarges, making it difficult for the heart to pump enough blood), Atrail Fibrillation, Depression, Hypertension (high blood pressure) and morbid Obesity (A disorder that involves having too much body fat, which increases the risk of health problems.) Obstructive Sleep Apnea.

Review of the Resident's Comprehensive Care Plan dated 5/31/24 showed:
-Use of CPAP at night; the resident frequently refused staff to assist with placement.

Review of the Resident's August physician orders showed:
-CPAP with 2 liters of O2 on at bedtime and off in AM every shift. Order date of 5/25/24
-No orders for cleaning or changing tubing/masks

Observation on 8/12/24 at 9:32 A.M. showed:
-The CPAP machine was sitting on the nightstand, the mask was laying on the overbed table, condensation in the mask tubing.
-The tubing was not dated.
-The humidifier was not dated.
-Three partial gallons of distilled water sitting on floor , open and undated.

Observation and interview on 8/13/24 at 9:22 A.M. showed:
-The CPAP machine was sitting on the nightstand, the mask was laying on the overbed table, condensation in the mask tubing.
-The tubing was not dated.
-The humidifier was not dated.
-Three partial gallons of distilled water sitting on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 695	Continued From page 44 the floor, open and undated. -The resident said -Staff assisted him/her to put the CPAP on when he/she wanted it on. -The gallons of distilled water were for his/her CPAP machine. -He/She was not sure when the gallons of water had been opened. -He/She was not sure when the machine is cleaned. -The mask and tubing were maybe changed once a month. During an interview on 8/19/24 at 10:30 A.M. Licensed Practical Nurse A said: -The residents take the CPAP masks off themselves, and he/she checks them at morning rounds. -He/She did not clean the masks daily. -He/She was not aware the masks needed to be cleaned daily. -Tubing and masks are changed monthly . During an interview on 8/14/24 at 3:19 P.M. the Director of Nursing said: -There should be a physician order for use of CPAP machine. -CPAP cleaning should be done by manufacturers guidelines or weekly. -Distilled water should be dated when opened and was only usable for 30 days once opened. -The Charge Nurse is responsible for cleaning and care of the CPAP machines.	F 695		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are	F 699		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 699	Continued From page 45	F 699		

trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to provide trauma informed care to one sampled resident (Resident #30) with a diagnosis of Post-Traumatic Stress Disorder (PTSD, a mental health condition that is triggered by a terrifying event). The facility census was 33.

The facility did not provide a policy on Trauma Informed Care.

Review of Resident #30's Admission Minimum Data Set (MDS: a federally mandated assessment tool completed by facility staff) dated 7/30/24 showed:
-Brief Interview of mental status (BIMS) of 15, indicated no cognitive loss
-Set up assistance of staff for Activities of Daily Living (ADLs: activities done in a day to care for oneself)
-Diagnoses of : Chronic Obstructive Pulmonary Disease (COPD: A lung disease that causes breathing problems and restricted airflow.) Chronic Atrial Fibrillation (Afib: a heart condition that causes rapid, irregular heart beats) Post Traumatic Stress Disorder (PTSD:A disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event.) Depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and Anxiety (a feeling of dread, fear, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 699	Continued From page 46	F 699		

uneasiness).

Review of the August Physician order sheet showed the resident may see behavioral health as needed with an order date of 7/23/24.

Review of the resident's medical record showed:
-The Social Services assessment completed 7/26/24 was marked no for any history of trauma.
-No behavior interventions, or psychiatric evaluation/assessment completed.
-No care plan for diagnosis of PTSD,

During an interview and observation on 08/13/24 at 11:35 AM showed:
-He/She gets very nervous and worked up about things.
-He/she felt worried and upset.
-He/She was hurt most of his/her childhood and has nightmares about that time.
-The facility has not done anything to help with the anxiety and nightmares.
-The nurses were good about listening to him/her.
-He/She does not see a professional and has not been told that is an option.
-He/She felt he/she just needed some help.
-He/She was crying, his/her hands were shaking and he/she ran his/her hands through their hair over and over.

During an interview on 08/13/24 at 11:50 AM the Social Service Director said:
-She did not set up behavioral health appointments.
-Behavioral health is contracted and that office sends a list of residents to be seen every month.
-The office was notified of new admissions and adds them to the list of residents to see.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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SUNSET HOME	1201 S POLK MAYSVILLE, MO 64469

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F 699	Continued From page 47 During an interview on 8/14/24 at 3:19 P.M. the Director of Nursing said: -There was a resident diagnosed with PTSD. -Behavioral health goes to the facility monthly. -The residents care plan should include the diagnosis of PTSD.	F 699		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility staff failed to assess residents for risk of entrapment from bed rails prior to installation and failed to ensure the bed's dimensions were appropriate for the residents	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 700	Continued From page 48	F 700		

size and weight, and additionally failed to complete quarterly assessments side rail and entrapment assessments (Resident #20, #13, #14, and #21), and failed to obtain a physician's order prior to installation (Resident #20, #13, and #14), failed to obtain informed consent (Resident #13, #14, and #21) for four of the 12 sampled residents (Resident #20, #13, #14, and #20). The facility census was 33.

Review of facility policy, bed rails, undated, showed:
-Once bed rail observation is completed, the facility will print the observation and review associated risks and benefits with the resident and/or resident representative. After review is complete, the resident and/or resident representative will sign the consent line and nurse will sign as well.
-Develop a care plan that outlines the medical factors necessitating bed rails and an explanation of how the use of a bed rail is intended to treat the specific resident's condition.
-When installing or maintaining bedrails, staff should follow manufactrer's recommendations and specifications for applicable bed rails, mattresses, and bedrames.
-Staff will conduct regular inspections of all bedframes, mattresses, and bed rails, to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility will select equipment such as bed rails, mattresses, and bedframes that are compatible.
-Overview of FDA potential zones of entrapment with FDA dimension recommendations:
-Zone 1: within the rail
-Any open space between the perimeters of the rail can present a risk of head entrapment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 700	Continued From page 49	F 700		

FDA recommended space: less than 4 and 3/4 inches

-Zone 2: Under the Rail, Between the Rail supports or next to a signle rail support

-The gap under the rail between the mattress, may allow for dangerous head entrapment. FDA recommended space: less than 4 and 3/4.

-Zone 3: Between the rail and the mattress

-The area is the space between the inside surface of the bed rail and the mattress, and if too big it can cause a risk of head entrapment. FDA recommended space: less than 4 and 3/4 inches;

-Zone 4: Under the rail at the ends of the rail.

-A gap between the mattress and the lowermost portion of the rail poses a risk of neck entrapment. FDA recommended space is less than 2 and 3/8 inches.

-Zone 5: Between split bed rails

-When partial length head and split rails are sued on the same side of the bed, the space between the rails may resent a risk of either neck or chest entrapment.

-Zone 6: Between the end of the rail and the side edge of the head or foot board

-A gap between the end of the bed rail and the side edge of the headboard or footboard can present the risk of resident entrapment.

-Zone 7: Between the head or foot board and the end of the mattress

-When there is too large of space between the inside surface of the headboard or footboard and the end of the mattress, the risk of head entrapment increases.

-Prior to use of bed rails the facility should complete the matrix bed rail observation including the following:

1. Observation detail
2. Clinical Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 700	Continued From page 50	F 700		

3. Alternatives attempted prior to bed rail implementation.
4. Bed rail details.
5. Assessment of potential entrapment zones.
6. Review of risk and benefits with resident and resident representative
7. Obtain informed consent with resident and/or resident representative signature
8. Obtain physician order for medical symptom assessed requiring bed rail use

Review of the undated bed rail policy showed:
- Bed rail use was to be care planned;
- Bed rails should have regular inspections of the bed frames, mattresses and bed rails to identify possible areas of entrapments;
- Prior to the installation of bed rails the facility staff should complete the bed rail observation in the Electronic Medical Record (EMR) that includes observation detail, clinical assessment, alternatives attempted prior to bed rail installation, assessment of potential entrapment zones, obtain informed consent with the resident, and obtain a physician's order for the bed rail use.

1. Review of Resident #20's Quarterly minimum data set (MDS), A federally mandated assessment tool completed by facility staff, dated 6/25/24, showed:
-He/She had moderate cognitive impairment;
-He/She had clear speech, was able to make self-understood and understand others;
-He/She was dependent on staff for bed mobility and positioning;
-He/She had 1 fall with no injury since prior assessment dated 3/25/24;
-He/She was taking antidepressant, anticoagulant, antibiotic, diuretic, opiod, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 700	Continued From page 51	F 700		

hypoglycemic medication;
-Diagnoses included multiple sclerosis (a disease in which the immune system eats away at the protective covering of nerves), coronary artery disease (a condition resulting in narrowing coronary arteries limiting blood flow to the heart), hypertension, renal insufficiency (condition in which the kidneys lose the ability to remove waste and balance fluids), depression, asthma, cellulitis of right lower limb (a skin infection caused by bacteria), pain, polyneuropathy, generalized muscle weakness, sleep apnea, neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet).

Review of care plan, dated 9/19/18, showed:
-Resident required assistance with ADLS due to increased weakness related to his/her disease progression;
-He/She had quarter bed rail to aid with positioning and transfers.

Review of physician's orders, dated 8/12/24, showed:
-He/She did not have orders for any side rail.

Observation on 8/12/24 at 9:48 A.M. showed resident had a side rail up on his/her left side of the bed.

During an interview on 8/14/24 at 12:23 P.M., Resident said he/she had side rails on right side to help boost him/her up in bed.

Review of electronic medical record showed:
-On 12/27/23, one bed rail facility assessment was incomplete with missing zone information and the only assessment completed in the medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNSET HOME	1201 S POLK MAYSVILLE, MO 64469

(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 700	Continued From page 52	F 700		

-A quarter side rail would be used to assist with positioning and transfers;
-Frequency of use was while in bed to assist with positioning;

During an interview on 8/14/24 at 9:30 A.M., CNA B said:
-He/She did not know why resident has side rails on his/her bed

During an interview on 8/14/24 at 1:03 P.M., the Administrator said:
-He/She expected side rails to be assessed quarterly for entrapment assessments;
-The Director of Nursing (DON) was responsible for completing entrapment assessments;
-Side rails should have physician's orders.

During an interview on 8/14/24 at 1:21 P.M., DON said:
-A physician's order must be obtained for side rails;
-He/She did not know he/she was responsible for doing entrapment assessments until this week;
-He/She was aware the MDS Coordinator had done some of the entrapment assessments for side rails;
-Side rail and entrapment assessments should be completed quarterly;
-Measurements of bed frame, mattresses, and side rails should be done with quarterly assessments;
-He/She had not done side rail assessments.

During an interview on 8/14/24 at 1:36 P.M., the Maintenance staff said:
-He/She had never installed any side rails at the facility;
-He/She did not complete any measurements on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 700	Continued From page 53	F 700		

side rails, mattresses, or bed frames.
2. Review of Resident #13's quarterly Minimum Data Set, (MDS, a federally mandated assessment completed by the facility staff), dated 8/4/24 showed:
- The resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment;
- He/She required substantial assistance to get dressed, use the toilet and to bathe;
- Diagnoses included: Bipolar disorder (mood swings that range from depression to very happy), Atrial Fibrillation (a disorder in which the heart does not beat correctly), epilepsy (seizure disorder), and Chronic Obstructive Pulmonary Disease (COPD).

Observation on 8/12/24 at 9:55 A.M. showed:
- A bed rail attached to the side of the residents bed and leaning away from the bed.

Review of residents record showed the following:
- The care plan addressed the use of a bed rail for the resident to assist with repositioning;
- No bed rail assessment;
- No entrapment assessment;
- No consent for the use of the bed rail;
- No physicians order for the use of a bed rail.

3. Review of Resident #14's quarterly MDS dated 6/26/24 showed:
- He/She had a BIMS score of 11, indicating moderate cognitive impairment;
- He/She was dependent on the staff to use the toilet, get dressed and to shower;
- Diagnoses included: Stroke, anxiety, pneumonia (an infection of the lungs), and frequent falls.

Observation on 8/12/24 at 2:17 P.M. showed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 700	Continued From page 54	F 700		

- The resident was lying in bed sleeping;
- The resident had a 1/2 side rail on the right of his/her bed;
- The side rail was leaning away from the bed.

Observation on 8/13/24 at 9:52 A.M. showed;
- The resident was in bed sleeping;
- The bed rail was in the up position and leaning away from the bed.

Review of the resident record showed the following:
- No bed rail assessment;
- No entrapment assessment;
- No consent for the use of bed rails;
- No alternatives documented prior to the use of bed rails;
- No physicians order for the use of a bed rail;
- The care plan did not address the use of a bed rail.

4. Review of Resident #21's quarterly MDS dated 7/27/24 showed:
- BIMS score of 8, indicating moderate cognitive impairment;
- He/She required assistance with transfers, bathing, toilet care, and getting dressed;
- Diagnoses included: Bipolar disorder, weakness and psychosis.

Observation on 8/13/24 at 9:58 A.M. showed:
- The resident had 1/2 bed rails to both sides of his/her bed;
- Both bed rails were in the up position.

Review of the residents record showed the following:
- A physicians order dated 11/15/23 for the use of the left and right bed rail for transfers and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 700	Continued From page 55 repositioning; - The care plan addressed the use of the bed rails; - No bed rail assessment; - No entrapment assessment; - No bed rail consent. 5. During an interview on 8/13/24 at 10:21 A.M. the Administrator said: - She expected the use of a bed rail to have a physicians order; - She expected the care plan to address the use of bed rails; - She expected alternative methods to be documented prior to the use of a bed rail; - She expected bed rail assessments and entrapment assessments to be completed prior to the installation of the bed rail; - She expected bed rail consents to be obtained and documented prior to the installation of bed rails.	F 700		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that	F 726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 726	Continued From page 56	F 726		

licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to provide competency assessments in accordance with their facility assessment, when they failed to ensure 7 of 7 randomly selected nurse aides, had competency assessments at hire and every 6 months thereafter. This potentially effected all residents. The facility census was 33.

The facility did not provide a policy for competency and education.

Review of the Facility Assessment dated 6/20/24 showed:
-Competencies will be tested every 6 months and those indicated by star will be tested at hire, for nursing staff.
-Person Centered Care
-Activities of Daily Living*
-Disaster Procedures*
-Infection Control*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 726	Continued From page 57	F 726		

-Medication Administration*
-Wound Care*
-Measurements*
-Resident assessments and observations
-Caring for residents with all forms of dementia*
-Specialized care-such as catheter insertion (a tube inserted into the bladder to drain urine), colostomy care (an artificial opening in the stomach to drain feces), etc.
-Caring for residents with mental and psychological disorders- (including Trauma and Post Traumatic Stress Disorder (PTSD: a mental health condition that's caused by an extremely stressful or terrifying event)- implementing nonpharmacological (non medication) interventions*

Review of employee files and education records showed:
-Certified Nurse Aide (CNA) F
- Date of hire 10/21/2014
-No competency completed for 2024
-CNA G
-Date of hire 5/7/22
-No competency completed for 2024
-CNA E
-Date of hire 7/17/23
-No competency completed for 2024
-CNA D
-Date of hire 12/27/23
-No competency completed for 2024
-Nurse Aide A
-Date of hire 7/6/23.
-No competency completed for 2024

-Nurse Aide B
-Date of hire 3/14/24
-No competency at time of hire

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 726	Continued From page 58 -No competency for 2024 -Nurse Aide C -Date of hire 7/16/24 -No competency at the time of hire During an interview on 8/14/24 at 3:19 P.M. with the Director of Nursing (DON) and Administrator: The DON said: -Competency assessments were to be completed annually or more often as needed. -If there is a concern with care, a competency would be completed, such as a rise in urinary tract infections . -She was not aware the Facility Assessment showed competency was to be done every 6 months. The Administrator said: -Most education is based on findings from the quarterly Quality Assurance meeting. -Competency should be completed annually and as needed. -She did not know the Facility Assessment showed competency was to be done every 6 months and at the time of hire.	F 726		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 727	Continued From page 59	F 727		

§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for eight consecutive hours per day seven days a week. This deficiency had the potential to affect all residents. The facility census was 33.

The facility did not provide a policy regarding RN coverage.

Review of the facility staffing and time sheets showed no RN in the facility within a 24 hour time period on:
-July: 20th and 21st.
-August: 3rd and 4th.

During an interview on 08/14/24 at 11:30 A.M. the Administrator said:
-The facility had a waiver for RN coverage so she did not worry about not having a RN in the facility on those days.
-There facility used two staffing agencies that provided RN coverage at times.
-There was an add on-line for a RN.
-There was a RN on call 24 hours a day, 7 days a week, either the Director of Nursing or a Corporate Nurse.
-There is no care that requires a RN.
-The facility did admit residents on Medicare services.
-She filed for a waiver for RN coverage on June 24, 2024 and has not received approval from CMS to waive RN coverage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 728	Continued From page 60	F 728		
F 728 SS=E	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent	F 728		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 728	Continued From page 61	F 728		

as provided in §483.150(a) and (b).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure two nurse aides (NA) completed a nurse aide training program within four months of his/her employment in the facility. The census was 33.

The facility did not provide a policy on education and Certified Nurse Aide training.

Review of the Facility Assessment, completed by facility staff, dated 6/27/24 showed:
-Nursing staff must have a license/certification current and verifiable with the State of Missouri. NA's will be hired with the certainty they will be in a Certified Nursing Assistant class within 120 days.

Review of employee files showed the following:
-Nurse Aide (NA) A date of hire 7/6/2023
    -no competency evaluation
    -Certification issued 5/24/2024
-NA B date of hire 3/14/2024
    -no competency evaluation
    -no certification issued

Review of the Missouri CNA Registry on 8/14/24 showed:
-NA A certification was issued 5/24/24
-NA B was not found

During an interview on 8/14/24 at 11:30 A.M. the Administrator said:
- There were two NA's working in the facility and one that was certified in the last 90 days.
-The 2 NA's are in Certified Nurse Aide training on line.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 728	Continued From page 62 -She is unsure if the Director of Nursing provides a competency evaluation before NA's have contact with residents. -NA A and B did not finish classes in the 4 month time frame because of missed classes. -She was aware the staff did not finish in the allotted time. -Staff should understand that missing class would mean they cannot work. -She is unsure why the staff were still employed after 4 months.	F 728		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year, failed to provide nurse aide's annual individual performance review or evaluation, failed to provide the required annual competency of Dementia Care, and failed to implement a tracking system for monitoring training hours. This effected 5 of the 7 sampled nurse aides (Certified Nurse Aide; (CNA) E and CNA F) and had the potential to effect all staff and residents. The facility's census was 33. The facility did not provide a policy regarding staff education.	F 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 730	Continued From page 63	F 730		

Review of the Facility Assessment dated 6/20/24 showed:
-Competencies will be tested every 6 months and those indicated by star will be tested at hire, for nursing staff.
-Person Centered Care
-Activities of Daily Living*
-Disaster Procedures*
-Infection Control*
-Medication Administration*
-Wound Care*
-Measurements*
-Resident assessments and observations
-Caring for residents with all forms of dementia*
-Specialized care-such as catheter insertion (a tube inserted into the bladder to drain urine), colostomy care (an artificial opening in the stomach to drain feces), etc.
-Caring for residents with mental and psychological disorders- (including Trauma and Post Traumatic Stress Disorder (PTSD: a mental health condition that's caused by an extremely stressful or terrifying event)- implementing non-pharmacological (non medication) interventions*
-Staff Training/Education:
-Abuse, neglect and exploitation training will be given to the whole staff at least twice a year,
-Infection control with mandatory in-services o the facility policies and procedures,
-On-going inservices for culture change: person centered/directed care,
-Required inservices for nurse aides:
1. Body Mechanics
2. Prohibition of abuse, neglect, exploitation and misappropriation
3. Tornado safety, missing resident,

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	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 730	Continued From page 64	F 730		

elopement protocol, incontinent care, catheter care/change,

4. Resident rights, physical assessments, infection control,

5. Universal precautions, eye wash stations, spills/blood cleanup, pharmacy, oxygen and Continuous positive airway pressure (CPAP : a machine that uses mild air pressure to keep the airways open while a person sleeps)

6. Normal nutrition, dining room monitoring, feeding techniques, Restorative dining, Adaptive equipment

7. Emergency preparedness, communication, The Health Insurance Portability and Accountability Act (HIPAA: a federal law that was passed in 1996 to protect the confidentiality and security of patient health information), blood glucose, denture/dental/mouth care.

8. Behavioral health care and services, Dementia management, behavior management, documentation of behaviors

9. Tuberculosis (TB) testing, drug testing, immunizations/vaccinations, restraints/personal alarms/bed rails, wound and skin care,

10. Disasters and the plan for each, communicable diseases, hand washing, gloving and hand gel use, Electronic Medical Record documentation.

11. Fall prevention and root cause analysis, event reports, wound care management, pressure ulcer prevention.

12. Heimlich maneuver, Do Not Resuscitate (DNR)/ Cardiopulmonary Resuscitation (CPR), death and dying, hospice, Restorative Nursing

-Assessing and reporting change in condition,

-On going education on the social, cultural and language needs of residents.

Review of employee files and education records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 730	Continued From page 65	F 730		

showed:
-Certified Nurse Aide (CNA) F
- Date of hire 10/21/2014
-No proof of education tracking
-Education on mechanical lift, transfer training completed 6/10/24,
-Hand Hygiene competency dated 8/6/24
-CNA G
-Date of hire 5/7/22
-No proof of education provided
-No education tracking
-Education on resident rights dated 5/10/24
-Competency on hand hygiene dated 8/9/24
-CNA E
-Date of hire 7/17/23
-No tracking of education
-Education on resident rights dated 5/10/24, mechanical lift and transfer training dated 6/10/24, and toileting schedules/shower sheets dated 8/9/24
-Competency completed for perineal care dated 8/12/23
-
-CNA D
-Date of hire 12/27/23
-No competency completed for 2024
-No education tracking
-Education on mechanical lift and transfer training dated 6/10/24

-Nurse Aide A
-Date of hire 7/6/23.
-No competency completed for 2024
-No education tracking
-No proof of education

During an interview on 8/14/24 at 3:19 P.M. with the Director of Nursing (DON) and Administrator: The DON said:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 730	Continued From page 66 -Competency assessments were to be completed annually or more often as needed. -If there is a concern with care, a competency would be completed, such as a rise in urinary tract infections . -She was not aware the Facility Assessment showed competency was to be done every 6 months. -Education is done annually. -There is not a tracking system in place -She received a calendar with scheduled education this week. -She was not aware staff did not have enough education hours. The Administrator said: -Most education is based on findings from the quarterly Quality Assurance meeting. -Competency should be completed annually and as needed. -She did not know the Facility Assessment showed competency was to be done every 6 months and at the time of hire. -CNA's must have 12 hours of training annually. -Education is completed on pay days. -Several topics may be discussed at one meeting -There is no tracking system for education and hours of education -When a staff member misses a pay day meeting, that staff member must meet with the DON or Administrator one on one. -She was not aware staff did not have 12 hours of education.	F 730		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 804	Continued From page 67	F 804		

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
Based on observation and interviews, the facility failed to ensure staff served food to the residents that was palatable, attractive, and served at a safe and appetizing temperature when hot food was not served at an appetizing temperature for four of twelve sampled residents (Resident #2, #13, #21, and #185) . The facility had a census of 33.

Review of facility policy, Food Temperatures, dated May 2015, included hot foods should be at least 120 degrees Fahrenheit when served to the resident.

1. Review of Resident #2's Quarterly minimum data set (MDS), a federally mandated assessment tool completed by facility staff, dated 5/13/24, showed:
-He/She had moderate cognitive impairment;
-He/She had clear speech and was able to make-self understood and understand others;
-He/She was dependent on a wheelchair and walker;
-He/She required set up or clean up assistance with eating;
-He/She was on a mechanically altered diet;
-Diagnoses included Parkinson's disease (a progressive disorder that affects the nervous system and parts of the body controlled by the nerves), high blood pressure, chronic pain,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 804	Continued From page 68	F 804		

tendency to fall, reduced mobility, need for assistance with personal care, history of falling, I44.1, generalized muscle weakness, unsteadiness on feet, and cognitive communication deficit (a condition affecting a person's ability to think, learn, remember, use judgement, and make decisions).

During an interview on 8/12/24 at 1:35 P.M., Resident said his/her food was not always served hot.

2. Review of Resident #21's Quarterly MDS, dated 7/27/24, showed:
-He/She had moderate cognition;
-He/She had clear speech;
-He/She was able to make self-understood and understand others;
-He/She was dependent on walker or wheelchair;
-He/She required set up or clean up assistance with eating;
-Diagnoses included bipolar disorder, need for assistance with personal care, tendency to fall, and schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms).

During an interview on 8/12/24 at 9:23 A.M., the resident said food is often cold and did not taste good.

3. Review of Resident #13's Quarterly MDS, dated 8/4/24, showed:
-His/Her cognition was intact;
-He/She had clear speech;
-He/She was able to make self-understood and understand others;
-He/She was dependent on a wheelchair;
-He/She required set up or clean up assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 804	Continued From page 69	F 804		

with eating;
-Diagnoses included muscle weakness, anxiety, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs), polyneuropathy (a decreased ability to move and feel sensation because of nerve damage), low back pain, and edema (a condition when tiny blood vessels in the body leak fluid).

During an interview on 8/12/24 at 9:51 A.M., the resident said food is often served to him/her cold.

4. Review of Resident #185's entry tracking MDS, dated 8/9/24, showed he/she entered from short term general hospital stay.

During an interview on 8/14/24 at 8:56 A.M. resident said he/she's breakfast was cold and food was not always warm.

During an interview on 8/12/24 at 9:21 A.M., Cook A said he/she did not temperature check breakfast that morning due to breakfast being served late.

During an observation in the kitchen start on 8/14/24 from 10:36 A.M.-11:58 A.M., showed:
-10:38 A.M. food items observed already on steam table included augratin potatoes, chicken, and peas
-10:43 A.M. hot dogs added to steam table, no temperatures were taken;
-10:48 A.M. Pureed augratin potatoes added to steam table;
-10:51 A.M. Dinner rolls added to steam table;
-10:59 A.M. No foods have been temperature checked since entry into the kitchen;
-11:16 A.M. No food temperatures have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 804	Continued From page 70	F 804		

observed since entering kitchen, observation on clip board for temperature log showed cooking temperatures and holding temperatures have already been recorded for lunch. Meat temped at 200, holding was 197, Starch 214, holding was 212, vegetable 210, holding was 205 degrees/
-11:30 A.M. Lunch service started serving when Cook A served up first plate, no food temperatures had been taken of food items on steam table;
-11:44 A.M. First trays going to be served to south side dining room'
-11:52 A.M. Last cart went to the south dining room.
-11:53 A.M. Test tray obtained and temperatures showed that the mechanical chicken was not at safe serving temperature when the temperature checked at 101. 3 degrees Fahrenheit (F). Items tested included peas at 157.8 degrees F, Parmesan chicken breast 173.9 degrees F, cup up potatoes 128.8 degrees F, augratin potatoes 130.7 degrees F, pork sausage puree 139.2 degrees F, saurkraut 152 degrees F.

During an interview on 8/14/24 at 11:58 A.M., Cook A said:
-He/She should temperature check foods before serving them;
-He/She did not temperature check foods on the steam table prior to lunch;
-He/She was not taught about food temperature checking when he/she first got hired on with facility;
-He/She temperature checked food when he/she removed it from the oven and stove top.

During an interview on 8/14/24 12:09 P.M. Dietary Aide A said:
-Food temperature checks should be done before

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 804	Continued From page 71 food was served; -Cook A did not temperature check foods prior to serving the lunch meal on 8/14/24; -Food should be temperature checked when it came out of oven and prior to serving on the steam table. During an interview on 8/14/24 at 1:03 P.M., Administrator said he/she expected food to be temperature checked before it was served from the steam table and prior to being put on steam table.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to prepare and serve	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 72	F 812		

food in accordance with professional standards for food service safety when staff failed to maintain a clean and sanitary kitchen, did not ensure refrigerator and freezer temperatures were checked daily, did not ensure proper function of dishwasher by testing and logging it daily, did not use sanitizer solution on kitchen food preparation surfaces, staff did not practice sanitary hand washing skills, and did not ensure proper storage and labeling of foods. Additionally the facility failed to ensure food temperatures were logged and measured during meal service and cooking. The facility census was 33.

Review of facility policy, handwashing, dated May 2015, showed:
-If using gloves, remove gloves;
-Roll down paper towels;
-Turn on water and run until warm;
-Wet hands and forearms with warm water;
-Lather hands with antiseptic soap;
-Wash hands, give particular attention to the areas between fingers, around cuticles, and under fingernails;
-Wash forearms well;
-Rinse thoroughly with warm water, beginning at the top of the forearm;
-Wipe hands dry with clean paper towel;
-Turn off water with paper towel and dispose of paper towel.

Review of facility policy, glove use, dated May 2015, showed:
-To ensure safe and proper food handling during food preparation and service. The food code states that food items should not be handled with bare hands.
-Utensils or tongs should be used to serve or handle foods, both raw and cooked, whenever

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 73	F 812		

possible;
-When serving, preference is not to use gloves unless only one task is being performed;
-When preparing or handling food items such as meatloaf or raw chicken, gloves should be worn;
-Hand washing per guidelines should occur between each task;
-Gloves should be worn if handing food is necessary. Extra caution should be taken when multiple tasks are being completed;
-Gloves should be removed when changing or walking away from specific tasks and hands should then be washed per guidelines.
-Note: hands should be washed:
-Before beginning each shift;
-After breaks;
-After using the restroom;
-After smoking or eating;
-After blowing nose;
-After disposing of trash or food;
-After handling dirty dishes;
-After handling raw meat, poultry or eggs;
-After picking up anything from the floor;
-When changing tasks;
-Any other time deemed necessary.

1.Review of facility policy, general dish room sanitation, dated May 2015, showed:
-An associate working on the soiled end of the dish machine must wash their hands before working on the clean end of the dish machine.

Observation of the kitchen during initial tour on 8/12/24 at 8:39 A.M. showed there was no paper towels at the handwashing sink.

During an interview on 8/12/24 at 8:54 A.M., Cook A said:
-He/She was out of paper towels right now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 74	F 812		

Observation of the kitchen during initial tour on 8/12/24 at 8:58 A.M. showed Cook A using a reusable cloth hand towel to dry his/her hands.

During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed:
-10:37 A.M., Cook A observed making puree in robot cook with gloves applied;
-10:40 A.M., Cook A rinsed out robot coupe at dishwasher, and added container to dishwasher and ran cycle;
-10:44 A.M., Cook A obtained robot coupe off dishwasher;
-10:48 A.M., Cook A removed his/her gloves. He/She did not wash his/her hands.
-10:48 A.M.. Cook A removed raw bags of chicken from two compartment sink and added to the trash container by hand washing sink.
-10:49 A.M., Cook A washed his/her hands. He/She used bare hands that he/she had just washed to turn off faucet, then obtained paper towel to dry of his/her hands
-10:50 A.M., Dietary Aide A washed his/her hands, turned off the faucet with his/her bare hands. He/She then obtained paper towel to dry of his/her hands.
-10:51 A.M., Dietary Aide A observed applying gloves;
-11:03 A.M., Cook A washed his/her hands, turned off faucet with his/her bare hands, then dried hands with paper towel.
-11:09 A.M., Cook A removed dishes from clean side of dishwasher. He/She then loaded additional items into dishwasher. He/She did not wash hands prior to grabbing items from clean side of dishwasher.
-11:28 A.M., Cook A applied gloves for meal service, he/she had not washed his/her hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 75	F 812		

-11:47 A.M., Cook A observed cutting up chicken with knife from steam table, then separating the meat using his/her gloves;

During an interview on 8/14/24 at 11:58 A.M., Cook A said:
-He/She should turn faucet off with paper towel;
-He/She did turn off faucet with bare hands when he/she washed his/her hands.

During an interview on 8/14/24 at 12:09 P.M., the Dietary Aide A said:
-He/She should wash hands every time he/she touched something different, his/her face, left the kitchen and re-entered the kitchen;
-It was not sanitary to touch faucet handle with his/her bare hands;
-He/She did touch faucet with bare hands when turning off the water;
-He/She wore gloves when he/she made drinks and did dishes.

During an interview on 8/14/24 at 1:03 P.M., the Administrator said:
-He/She expected dietary staff to wash hands between anything clean and dirty;
-He/She expected staff to glove when they were serving food, after they had touched anything they should remove gloves and wash his/her hands then re-glove;
-It was unsanitary to turn faucet off with bare hands after staff had just washed his/her hands;
-He/She expected paper towels to be available to staff in dietary department when drying their hands.

2. Review of facility policy, general dish room sanitation, dated May 2015, showed:
-All items must be stored inverted, covered, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 76	F 812		

stacked with top of dish/tray inverted (unless stored in an enclosed cabinet).

During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed:
-10:52 A.M., Drink pitchers all stored upright on metal shelf along wall by entry, a three-tiered cart positioned by the steam table had dinner plates and bowls that were all stored in an upright position.

During an interview on 8/14/24 at 11:58 A.M., Cook A said:
-He/She was unsure how pitchers, bowls, and plates should be stored but thought all dishware should be stored upright.

During an interview on 8/14/24 at 12:09 P.M., Dietary Aide A said:
-Pitchers, plates, and bowls should be stored inverted;
-The plates have always been stored upright since he/she had worked at facility;
-He/She did not flip pitchers upside down because he/she placed their tops on them.

During an interview on 8/14/24 at 1:03 P.M., Administrator said:
-He/She expected pitchers, plates, and bowls should be stored inverted.

3. Review of facility policy, cleaning schedules, dated May 2015, showed:
-It was responsibility of dining services manager to enforce the cleaning schedules and to monitor the completion of assigned cleaning tasks.
-Daily, weekly, and monthly cleaning schedules prepared by dining services manager with all cleaning tasks listed will be posted in dietary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 77	F 812		

department.

Review of facility policy, developing cleaning schedules, dated May 2015, showed:
-Grill was to be cleaned daily if used;
-Stove top to be cleaned daily;
-Dishwashing area to be cleaned daily;
-Stove was to be cleaned weekly;
-Under shelves to be cleaned weekly
-Oven was to be cleaned monthly

4. Review of facility policy, guidelines for cleaning gas stove, dated May 2015, showed:
-Oven will be cleaned weekly;
-Remove oven racks and place them on newspaper.

Review of facility policy, guidelines for cleaning stove, dated May 2015, showed:
-The stove top will be cleaned after use and the oven weekly.
-Wipe off any loose food.

Observation of the kitchen during initial tour on 8/12/24 at 8:43 A.M., showed:
-The stove had dried on brown food rumbles on burners
-Ledge of front of stove had grease and food crumbs;
-The side of the stove had spilled drips of food down the side;
-The handles of stove had grease and grime coating the handles and burner knobs.

During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed:
-11:01 A.M. showed the griddle on the oven stove top had food on it. Both side of range had food caked to it. There was drips of food running

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 78	F 812		

down side of oven. A stove rack was observed resting on the bare floor and leaning against the side of stove that had food crumbs spilled down side.

5. Review of facility policy, guidelines for cleaning microwave, dated May 2015, showed:
-Wash out spills and splatters as they occur, using a detergent solution.
-Sanitize with appropriate strength solution.

Observation of the kitchen during initial tour on 8/12/24 at 9:01 A.M. showed the outside of microwave was covered in food debris with a sticky, grimy substance on handle and buttons.

6. Review of facility policy, cleaning floors, dated May 2015, showed:
-Kitchen floor maintenance will be done after each meal. Spills need to be mopped up immediately.
-Sweep the floor, pushing all debris forward, using a dustpan to remove debris.
-mop one small area at a time, beginning at the rear of the room in a figure eight motion. Use a scraper to remove stubborn stains and debris on floor. Be sure to mop under and around equipment, along walls and in corners.
-Rinse the area with clean warm water, use a clean mop head.
-Wipe all splash and soil marks from baseboards and walls.

Observation of the kitchen during initial tour on 8/12/24 at 9:03 A.M. showed the floors had not been swept or mopped. There was spilled brown pudding like chocolate substance on the floor. Food debris was noted under the stove and drink preparation area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 79 During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed: -11:01 A.M. showed the area below the stove had not been swept or mopped. During an interview on 8/14/24 at 11:58 A.M., Cook A said: -Dietary manager did the deep cleaning of kitchen; -Dietary manager cleaned stove, oven, and griddle with a charcoal grip; -Appliances are deep cleaned every other week; -He/She tried to clean items as he/she went. During an interview on 8/14/24 at 12:09 P.M., Dietary Aide A said: -Sweeping and mopping of the kitchen floors was done at night; -Supervisor made him/her a cleaning map of who cleans what, he/she went through and did everything on the list except the stove; -He/She did not clean stove or oven because he/she did not want to mess anything up on it. During an interview on 8/14/24 at 1:03 P.M., Administrator said: -He/She expected cleaning to be done every evening and clean as they go in dietary department; -Dietary department was supposed to have a monthly cleaning log; -Appliance should be moved, swept and mopped underneath 7. Review of facility policy, Refrigerator and Freezer Temperatures, dated May 2015, showed: -There should be a thermometer in all refrigerator and freezers. Thermometers should be located	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 80	F 812		

in the front of the unit.
-Temperatures should be checked regularly in all refrigerators, at least every morning and every night.
-Refrigerator and freezer temperatures will be logged twice daily.

Observation of the kitchen during initial tour on 8/12/24 at 8:39 A.M. showed.
-The refrigerator and freezer temperature log that was hanging above the handwashing sink had no entries on 8/7 and 8/8.

During an interview on 8/12/24 at 9:21 A.M., Cook A said:
-The Dietary Aides were responsible for logging the temperatures of the refrigerators and freezers;

During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed:
-11:02 A.M. Observations of the cooler, refrigerator, and freezer temperature log was now completely filled out with no blanks on log. Previously the log was not filled out completely.

During an interview on 8/14/24 at 11:11 A.M., Cook A said:
-He/She had caught up on the logs when asked about the previous empty spaces on the logs;
-He/She said Dietary Aide A filled in the log on temperature reading;
-He/She did not know how staff remembered previous readings if they did not record them right away.

During an interview on 8/14/24 at 1:03 P.M., Administrator said:
-He/She expected staff to check the freezer and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 81	F 812		

refrigerator temperatures every shift;
-He/She expected there to be no blanks on the temperature recording log.

8. Review of facility policy, Dishwashing temperatures, dated May 2015, showed:
-Chemical sanitizer machine. Range to be effective 75-120 degrees F.
-The dishwasher machine temperatures will be recorded for the wash and rinse cycle daily for chemical sanitized (in addition to a sanitizer test strip), or each meal for high temperature sanitized or as directed by the consultant dietician.

Review of facility policy, dish machine sanitation, dated May 2015, showed:
-Check the machine for the next operation;
-After breakfast and lunch, refill machine and turn heaters on for the next meal;

Facility did not provide a policy on dishwasher de-liming.

Observation of the kitchen during initial tour on 8/12/24 at 8:41 A.M. showed:
-The dish machine temperature log had no entries on 8/9, 8/10 and 8/11 for breakfast, lunch and dinner.

During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed:
-10:42 A.M., The dishwasher was observed with crumbs of brown substance all over the top of it, it was not clean.
-11:02 A.M. observation of dish machine temperature log showed there was no blank entries.
-11:11 A.M., Cook A ran test strip of dishwasher

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 82	F 812		

which showed 100 PPM.

During an interview on 8/14/24 at 11:14 A.M. with Dietary Aide A said:
-He/She did dishwasher sanitizer readings;
-He/She completed the log after he/she is almost done with dishes;
-He/She said that he/she checked the temperature of dishwasher before he/she washed dishes;

During an interview on 8/14/24 at 11:58 A.M., Cook A said:
-He/She did not know when dishwasher de-liming was performed.

During an interview on 8/14/24 at 12:09 P.M., Dietary Aide A said:
-There is someone that comes into facility one time a month to delime dishwasher and check to ensure functioning properly.
-His/Her supervisor told him/her to filled in the blank spaces on the dish machine log;

During an interview on 8/14/24 at 1:03 P.M., Administrator said:
-He/She did not know expectation of de-liming of dishwasher;
-He/She would not expect the dishwasher to have brown substance covering the top of the dishwasher.

8. Review of facility policy, Food Temperatures, dated May 2015, showed:
-The DSM or designee is responsible for seeing that all food is the proper serving temperature(s) before trays are assembled.
-Keep the temperature of hot foods no less than 140 degrees F during meal services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 83	F 812		

-To ensure adequate temperatures, proper-holding techniques should be used.
-Food is not placed in the steam table more than 30 minutes before meal service.

Observation of the kitchen during initial tour on 8/12/24 at 8:47 A.M. of the food temperature logs from 6/12/24-8/12/24 that were on a clipboard on kitchen counter next to stove, showed:
-There was no log that had been started for breakfast that had already been served on 8/12;
-There was no food temperatures recorded for supper on 6/12, 6/13, 6/14, 6/15, 6/17, 6/18, 6/19, 6/20, 6/22, 6/24, 6/25, 6/26, 6/28, 6/29, 6/30, 7/1, 7/2, 7/3, 7/6, 7/7, 7/10, 7/12, 7/13, 7/14, 7/15, 7/16, 7/17, 7/21, 7/22, 7/23, 7/24, 7/25, 7/27, 7/31, 8/1, 8/2, 8/5, 8/9, 8/10, and 8/11
-There was only one entry for lunch on 7/30;

During an interview on 8/12/24 at 9:21 A.M., Cook A said:
-He/She did not temperature check breakfast that morning due to breakfast being late;
-The cook was responsible for documenting cooking temperatures;

During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed no cooking or holding temperature logs had been taken at supper on 8/12 and 8/13 meals;

During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed:
-10:38 A.M., Food observed already covered on steam table included cut up potatoes, au gratin potatoes, parmesan chicken breast, and peas;
-10:41 A.M., Cook A removed a bag of cooked hot dogs in boiling water from stove top, empties hot dogs into a metal container and poured hot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 84	F 812		

water from boiling container into metal container with hot dogs;
-10:43 A.M., Cook A added hot dogs added to steam table, no cooking temperatures were taken of hot dogs;
-10:48 A.M., Cook A obtained au gratin potatoes from robot coupe and added to steam table;
-10:51 A.M. Dinner rolls were added to steam table;
-10:59 A.M., Cook A had not temperature checked any food items since entry into the kitchen at 10:36 A.M.;
-11:16 A.M. No food temperatures had been observed since entering kitchen at 10:36 A.M.,, observation on clip board for temperature log showed cooking temperatures and holding temperatures had already been recorded for lunch. The meat temperature was recorded at 200 degrees F with a holding was 197, the starch was recorded at cooking temperature of 214 F and a holding was 212 degrees F, and the vegetable cooking temperature was recorded at 210 degrees F with a holding was 205 degrees F.
-11:30 A.M., Cook A served up first lunch plate, no food temperatures taken from items that were on steam table.

During an interview on 8/14/24 at 11:58 A.M., Cook A said:
-He/She should temperature check foods when he/she pulled items out of the oven to obtain cooking temperature and right before he/she served food;
-He/She did not temperature check foods prior to serving on 8/14/24;

During an interview on 8/14/24 at 12:09 P.M., Dietary Aide A said:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 85 -Food temperatures are done before food was served; -Food is temperature checked right after it came out of oven or stove top and right before it went on steam table; -Cook A did not temperature check food on steam table today. During an interview on 8/14/24 at 1:03 P.M., Administrator said: -He/She expected staff to temperature check foods prior to placing foods on steam table and prior to serving foods. 9. Facility did not provide a policy on sanitizer solution. Observation of the kitchen during initial tour on 8/12/24 at 8:47 A.M. showed there was no sanitizer solution out in kitchen. Observation of the kitchen during initial tour on 8/12/24 at 9:09 A.M. showed there was hot soapy water in two compartments sink and dish soap sitting out by the faucet. Observation of the kitchen during initial tour on 8/12/24 at 9:21 A.M. showed washcloth sitting out on counter. During an interview on 8/12/24 at 9:21 A.M., Cook A said: -He/She used hot water with soap to wipe off surfaces in the kitchen; -He/She did not use sanitizer on kitchen surfaces; -He/She used sanitizer water out in the dining room to sanitize tables;	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 86 During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed: -10:37 A.M., empty bags of raw chicken and raw pieces of chicken were observed in the 2 compartment sink where dish soap was previously observed and used to sanitize kitchen surfaces; -10:40 A.M., There was two red sanitizer buckets out and filled with water on counter tops in kitchen. One located by two compartment sink and a second located by drink preparation counter. -10:48 A.M.. Cook A removed raw bags of chicken from two compartment sink and added to the trash container by hand washing sink. -10:51 A.M., a washcloth was laying on surface of steam table, not in sanitizer water; -10:54 A.M., Cook A removed his/her gloves and placed in trash can, he/she then grabbed sanitizer water and washcloth out of bucket and started wiping off surfaces by robot coupe; -10:55 A.M., Cook A put a test strip in sanitizer bucket which showed it was white showing no parts per million (PPM) of solution) -10:56 A.M., Cook A dumped out sanitizer solution bucket and refilled bucket with solution from hose on wall by dishwasher; -10:57 A.M., Cook A dipped a second test strip into refilled bucket which showed it was white, revealing the solution tested 0 PPM. The bucket of sanitizer solution was observed to have suds in it. -10:58 A.M., Cook A used a washcloth dipped in the second refilled sanitizer solution bucket to wipe off the kitchen preparation surfaces table located behind the steam table. -10:58 A.M. raw pieces of chicken remain laying in drain of two compartment sink.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 87 During an interview on 8/14/24 at 10:55 A.M., Cook A said: -He/She did not test sanitizer buckets solution; -He/She normally did not test the sanitizer solution buckets; -He/She just placed sanitizer solution in the bucket directly from the solution on wall by dishwasher; During an interview on 8/14/24 at 11:58 A.M., Cook A said: -He/She had never set up sanitation buckets since he/she started working in kitchen; -He/She usually put water in the sink, added soap, and plugged up the drain; -Washcloths should be stored in the water when they were not in use During an interview on 8/14/24 at 12:09 P.M., Dietary Aide A said: -He/She sanitized surfaces in kitchen with sanitizer in red bucket and use of a washcloth; -Sanitizer buckets are set up depending on who is working; -Day shift normally sat out sanitizer solution; -He/She did not test sanitizer buckets for proper PPM During an interview on 8/14/24 at 1:03 P.M., Administrator said: -He/She expected kitchen surfaces to be sanitized using sanitizing solution and a washcloth; -Washcloths should be stored in sanitizing solution; -He/She expected staff to test sanitizer solution for proper parts per million; -He/She did not expect staff to document sanitizer solution test strips.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 88	F 812		

10. Facility did not provide a policy on trash cans.

Observation of the kitchen during initial tour on 8/12/24 at 8:39 A.M. showed:
-the trash can lid by hand washing sink was in the up position and did not close.

During a continuous observation of the kitchen on 8/14/24 from 10:36 A.M.-12:09 P.M., showed:
-11:35 A.M. Trash can in dishwasher area had no lid on it;

During an interview on 8/14/24 at 11:58 A.M., Cook A said:
-Trash cans in the kitchen should have lids on them;

During an interview on 8/14/24 at 12:09 P.M., Dietary Aide A said:
-The trash cans in the kitchen should have lids on them.

During an interview on 8/14/24 at 1:03 P.M., Administrator said:
-He/She expected trash cans in the kitchen to be covered.

11. Facility did not provide a policy on dating and labeling of foods.

Observation of the kitchen during initial tour on 8/12/24 at 9:05 A.M., showed
-In the Refrigerator in the kitchen:
    -Outdated meat sauce showed dated 8/7, throw out date of 8/10;
-In the kitchen:
    -Opened and undated package of hamburger buns;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 89	F 812		

-Opened and undated whole wheat loaf of bread;
-Opened and dated 8/1/24 package of potato chips;
-On the spice shelf:
-Opened and outdated 6/9/22 16oz whole celery seed;
-Opened and outdated 3/9/23 6oz rosemary leaves;
-Opened and undated 22 oz original chili container almost gone;
-Opened and unsealed package of 64 oz sugar with no opened date and a received 6/7/24;
-Opened and unsealed package of 32 oz flour, dated 4/16/24;
-Opened with no open date, 64 oz Mediterranean style oregano leaves dated received 4/7/23;
-Walk in cooler showed:
-Opened Hawaiian punch dated 1/20/23;

During an interview on 8/14/24 at 11:58 A.M., Cook A said:
-He/She did not know how long spices could be maintained before expiring;
-He/She dated food when it was made and then labeled it with a 3 day life span;
-If he/she made something on 8/14/24 then he/she would mark it as expired 3 days later;
-Dietary manager labeled food when it was received and then he/she was responsible for labeling food with the date that it was opened.

During an interview on 8/14/24 at 12:09 P.M., Dietary Aide A said food should be labeled and dated as soon as it was opened and when stored for leftovers.

During an interview on 8/14/24 at 1:03 P.M.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 812	Continued From page 90 Administrator said: -He/She expected food to be dated when it was received and when it was opened; -He/She expected spices to be thrown out after one year of opened date. 12. During an interview on 8/12/24 at 8:38 A.M. Cook A said: -He/She had worked in kitchen for almost a year; -Meals were served at 7:00 A.M., 11:30 A.M., and 5:00 P.M.; -He/She started serving to north dining room then transitioned to south dining room; -He/She usually worked evening meals; -He/She was working double shifts while the dietary manager was on vacation; During an interview on 8/14/24 at 11:58 A.M., Cook A said he/she had not had any training or in-services from the dietary manage. During an interview on 8/14/24 at 12:09 P.M., Dietary Aide A said: -He/She had been worked in the kitchen since September. -He/She had one day of training in kitchen; -He/She had to ask supervisor to train him/her on more stuff; -He/She worked full time in the kitchen;	F 812		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by:	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 921	Continued From page 91 Based on observation and interview, the facility staff failed to ensure they had a back flow preventer device (a device used to keep toxins from backing up into the facility's potable water supply) on all shower hoses. The facility census was 31. 1. Observation on 8/13/24 at 1:13 P.M., showed the shower hose in the shower room across from room six did not have a back flow preventer. During an interview on 8/13/24 at 1:13 P.M., the Maintenance Supervisor said he did not know all shower hoses needed to have a back flow preventer device.	F 921		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure they had an effective pest control program when the facility had gnats in the corridors and brown recluse spiders in the sprinkler riser room. The facility census was 31. 1. Review of the pest control logs showed no specific treatments for spiders or gnats. Observation on 8/13/24 at 2:43 P.M. showed the sprinkler riser room was a ten by ten by eight foot room. The room had at least five living spiders that moved around the room as the surveyor entered the room and at least a dozen dead	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

(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 925	Continued From page 92	F 925		

spiders in various levels of decay (some were just the exoskeleton) also lay on the wall and floor.

During an interview on 8/13/24 at 2:43 P.M. the Maintenance Supervisor said he did not think they had a specific routine for spiders in their pest control program.

During an interview on 8/14/24 at 2:30 P.M., the Administrator said they did not currently have a specific target for spiders with their pest control company. She knew general sprays would not generally kill brown recluse spiders. She did not know living and dead brown recluse spiders were in their sprinkler riser room.

Review of Resident #6 Annual Minimum Data Set (MDS: an assessment tool completed by facility staff) dated 6/6/24 showed:
-Brief Interview of Mental Status of 15, indicated no cognitive defecits
-Partial to moderate assistance of staff for bathing and dressing
-Supervision of staff for toileting and hygiene.
-Diagnosis of Traumatic Subdural hemorrhage (a serious medical condition that occurs when blood collects between the skull and the surface of the brain), hypertension, muscle weakness, dry mouth, and difficulty walking.

Review of the residents electronic medical record of a progress note dated 06/24/2024 at 2:29 PM showed:
-The resident returned from being out with family, with an area to the back of his/her right calf, that was red, swollen and scabbed. The resident was seen by the phyisican on 6/24/24. The physician said it looked like an abscess or aspider bite. New orders recived for Doxycycline

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265745	A. BUILDING _____ B. WING _____	08/14/2024

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

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F 925	Continued From page 93 (antibiotic) 100mg twice a day for 10 days and a topical treatment order. During an interview on 8/14/24at 3:19 P.M with the Administrator and the Director of Nursing: The DON said: -The resident had been out with his/her family. -The physician was unsure if the area was a spider bite, but it could have been. The Administrator said: -The resident was gone over a full weekend with his/her family. -They could not know for sure it was not a spider bite.	F 925		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced	F 947		

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F 947	Continued From page 94	F 947		

by:
Based on interview and record review, the facility failed to conduct at least 12 hours of nurse aide in-service education per year, failed to provide the required annual competency of Dementia Care and other required training's,and failed to prove education was completed from indicators of the Quality Assurance meetings. This effected 5 of the 7 sampled nurse aides (Certified Nurse Aide; (CNA) F, G,E, D and NA A) and had the potential to effect all staff and residents. The facility's census was 33.

The facility did not provide a policy for education.

Review of the Facility Assessment dated 6/20/24 showed:
-Competencies will be tested every 6 months and those indicated by star will be tested at hire, for nursing staff.
-Person Centered Care
-Activities of Daily Living*
-Disaster Procedures*
-Infection Control*
-Medication Administration*
-Wound Care*
-Measurements*
-Resident assessments and observations
-Caring for residents with all forms of dementia*
-Specialized care-such as catheter insertion (a tube inserted into the bladder to drain urine), colostomy care (an artificial opening in the stomach to drain feces), etc.
-Caring for residents with mental and psychological disorders- (including Trauma and Post Traumatic Stress Disorder (PTSD: a mental health condition that's caused by an extremely stressful or terrifying event)- implementing

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F 947	Continued From page 95	F 947		

nonpharmacological (non medication) interventions*
-Staff Training/Education:
-Abuse, neglect and exploitation training will be given to the whole staff at least twice a year,
-Infection control with mandatory in-services of the facility policies and procedures,
-On-going inservices for culture change: person centered/directed care,
-Required inservices for nurse aides:
1. Body Mechanics
2. Prohibition of abuse, neglect, exploitation and misappropriation
3. Tornado safety, missing resident, elopement protocol, incontinent care, catheter care/change,
4. Resident rights, physical assessments, infection control,
5. Universal precautions, eye wash stations, spills/blood cleanup, pharmacy, oxygen and Continuous positive airway pressure (CPAP : a machine that uses mild air pressure to keep the airways open while a person sleeps)
6. Normal nutrition, dining room monitoring, feeding techniques, Restorative dining, Adaptive equipment
7. Emergency preparedness, communication, The Health Insurance Portability and Accountability Act (HIPAA: a federal law that was passed in 1996 to protect the confidentiality and security of patient health information), blood glucose, denture/dental/mouth care.
8. Behavioral health care and services, Dementia management, behavior management, documentation of behaviors
9. Tuberculosis (TB) testing, drug testing, immunizations/vaccinations, restraints/personal alarms/bed rails, wound and skin care,
10. Disasters and the plan for each,

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F 947	Continued From page 96	F 947		

communicable diseases, hand washing, gloving and hand gel use, Electronic Medical Record documentation.

11. Fall prevention and root cause analysis, event reports, wound care management, pressure ulcer prevention.

12. Heimlich maneuver, Do Not Resuscitate (DNR)/ Cardiopulmonary Resuscitation (CPR), death and dying, hospice, Restorative Nursing

-Assessing and reporting change in condition,

-On going education on the social, cultural and language needs of residents.

Review of employee files and education records showed:

-Certified Nurse Aide (CNA) F

- Date of hire 10/21/2014

-No education tracking.

-Education on mechanical lift, and transfer training completed 6/10/24, signed by employee, did not show length of education, start or end time.

-CNA G

-Date of hire 5/7/22

-No education tracking

-Education on resident rights dated 5/10/24, signed by employee, did not show length of education, start or end time.

-CNA E

-Date of hire 7/17/23

-No tracking of education

-Education on resident rights dated 5/10/24, signed by employee, did not show length of education, start or end time.

-Education on mechanical lift and transfer training dated 6/10/24, did not show length of education, start or end time.

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F 947	Continued From page 97 -Education on toileting schedules/shower sheets dated 8/9/24, signed by employee, did not show length of education, start or end time. -CNA D -Date of hire 12/27/23 -No competency completed for 2024 -No education tracking -Education on mechanical lift and transfer training dated 6/10/24, signed by employee, did not show length of education, start or end time. -Nurse Aide A -Date of hire 7/6/23. -No competency completed for 2024 -No education tracking During an interview on 8/14/24 at 3:19 P.M. with the Director of Nursing (DON) and Administrator: The DON said: -Competency assessments were to be completed annually or more often as needed. -If there is a concern with care from the QA meetings, a competency would be completed, such as a rise in urinary tract infections . -She was not aware what the facility assessment said. -Education is done annually, on a calendar year. -There is not a tracking system in place -She received a calendar with scheduled education this week. -She was not aware staff did not have enough education hours. The Administrator said: -Most education is based on findings from the quarterly Quality Assurance meeting. -Competency should be completed annually and as needed.	F 947		

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	265745	A. BUILDING _____ B. WING _____	08/14/2024

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F 947	Continued From page 98 -She did not know the Facility Assessment showed competency was to be done every 6 months and at the time of hire. -CNA's must have 12 hours of training annually, per calendar year. -Education is completed on pay days. -Several topics may be discussed at one meeting -There is no tracking system for education and hours of education. -When a staff member misses a pay day meeting, that staff member must meet with the DON or Administrator one on one. -She was not aware staff did not have 12 hours of education.	F 947		

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	07798	A. BUILDING: _____ B. WING _____	08/14/2024

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

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A4103	19 CSR 30-85.042(94) Activities-Advance Notification The facility shall establish and maintain a program for informing all residents in advance of available activities, activity location and time. III This regulation is not met as evidenced by: *Class III* 1. Please refer to F679	A4103		
A4113	19 CSR 30-85.042(99)(D) Progress Notes - transfer/discharge Facilities shall ensure that the resident's clinical record must contain progress notes that include, *but are not limited to:* (D) Reasons for transfer or discharge. II/III This regulation is not met as evidenced by: Class II* *Higher classification merited to the extent of the violation. 1. Refer to F623 2. Refer to F625	A4113		
A6028	19 CSR 30-87.020(28) Backflow Requirements The potable water system shall be installed to preclude the possibility of backflow. Devices shall be installed to protect against backflow and back siphonage at all fixtures and equipment where an air gap at least twice the diameter of the water supply inlet is not provided between the water	A6028		

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	07798	A. BUILDING: _____ B. WING _____	08/14/2024

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A6028	Continued From page 1 supply inlet and the fixture ' s flood level rim. A hose shall not be attached to a faucet unless a backflow prevention device is installed. II This regulation is not met as evidenced by: Class II 1. Please refer to F921.	A6028		
A6031	19 CSR 30-87.020(31) Kitchen Waste Containers Covered Waste containers used in food-preparation and utensil-washing areas shall be kept covered when not in actual use. III This regulation is not met as evidenced by: Class III Please refer to F812.	A6031		
A6039	19 CSR 30-87.020(39) Inspect/Rodent Control Effective measures intended to minimize the presence of rodents, flies, cockroaches and other insects on the premises shall be utilized. The premises shall be kept in such condition as to prevent the harborage or feeding of insects or rodents. II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to to the impact on the residents. 1. Please refer to F925.	A6039		

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

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A6044	Continued From page 2	A6044		
A6044	19 CSR 30-87.020(44) Hand-Cleansing Soap/Towels Available A supply of hand-cleansing soap or detergent shall be available at each employee-use lavatory. A supply of sanitary towels or a hand-drying device providing heated air shall be conveniently located near each lavatory, except that hand towels for individual use are permitted. Common towels are prohibited. If disposable towels are used, easily cleanable waste receptacles shall be conveniently located near the hand-washing facilities. III This regulation is not met as evidenced by: Class III Please refer to F812.	A6044		
A7002	19 CSR 30-87.030(2) Wash Hands/Arms & Clean Fingernails Employees shall thoroughly wash their hands and the exposed portions of their arms with soap and warm water before starting work, during work as often as is necessary to keep them clean and after smoking, eating, drinking or using the toilet. Employees shall keep their fingernails clean and trimmed. II/III This regulation is not met as evidenced by: Class II *The higher classification merited due to the extent of the violation. Please refer to F812.	A7002		

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	07798	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A7034	Continued From page 3	A7034		
A7034	19 CSR 30-87.030(32) Metal Steam-Type Thermometers Used Metal stem-type numerically scaled indicating thermometers, accurate to plus or minus two degrees Fahrenheit (±2°F), shall be provided and used to assure the attainment and maintenance of proper internal cooking, holding or refrigeration temperatures of all potentially hazardous foods. II/III This regulation is not met as evidenced by: Class III Please refer to F812.	A7034		
A7036	19 CSR 30-87.030(34) Food-120 Degrees/Above, 45 Degrees/Below At time of service to the resident, food shall be at least one hundred twenty degrees Fahrenheit (120°F) or forty-five degrees Fahrenheit (45°F) or below. II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to the extent of the violation. 1. Refer to F804	A7036		
A7066	19 CSR 30-87.030(64) Grills/Griddles/Microwaves/Other-Clean Daily The food-contact surfaces of grills, griddles and similar cooking devices and the cavities and door seals of microwave ovens shall be cleaned at least once a day, except that this shall not apply	A7066		

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	07798	A. BUILDING: _____ B. WING _____	08/14/2024

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

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A7066	Continued From page 4 to hot oil-cooking equipment and hot oil-filtering systems. The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. III This regulation is not met as evidenced by: Class III Please refer to F812.	A7066		
A7067	19 CSR 30-87.030(65) Nonfood Contact Surfaces,Cleaned as Needed Nonfood-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles and other debris. III This regulation is not met as evidenced by: Class III Please refer to F812.	A7067		
A7068	19 CSR 30-87.030(66) Cloths for Food Service Only, Clean & Dry Cloths used for wiping food spills on tableware, such as plates or bowls being served to the consumer, shall be clean, dry and used for no other purpose. III This regulation is not met as evidenced by: Class III Please refer to F812.	A7068		
A7069	19 CSR 30-87.030(67) Moist Cloth-Kitchenware/Equip Clean/Sanitize	A7069		

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A7069	Continued From page 5 Moist cloths or sponges used for wiping food spills on kitchenware and food-contact surfaces of equipment shall be clean and rinsed frequently in one (1) of the permitted sanitizing solutions and used for no other purpose. These cloths and sponges shall be stored in the sanitizing solution between uses. Moist cloths or sponges used for cleaning nonfood-contact surfaces of equipment such as counters, dining table tops and shelves shall be clean and rinsed and used for no other purpose. These cloths and sponges shall be stored in the sanitizing solution between uses. III This regulation is not met as evidenced by: Class III Please refer to F812.	A7069		
A7070	19 CSR 30-87.030(68) 3 Compartment Sink-Wash/Rinse/Sanitize For manual washing, rinsing and sanitizing of utensils and equipment, a sink with not fewer than three (3) compartments shall be provided and used. Sink compartments shall be large enough to permit the accommodation of the equipment and utensils and each compartment of the sink shall be supplied with hot and cold potable running water, except that in an existing licensed facility, the use of a two (2)-vat sink and a supplementary portable container to be used for sanitization is acceptable. Fixed equipment and utensils and equipment too large to be cleaned in sink compartment shall be washed manually or cleaned through pressure spray methods. III This regulation is not met as evidenced by: Class III	A7070		

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	07798	A. BUILDING: _____ B. WING _____	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A7070	Continued From page 6 Please refer to F812.	A7070		
A7073	19 CSR 30-87.030(71) Equipment Cleaning Sequence in Sink Except for fixed equipment and utensils too large to be cleaned in sink compartments, manual washing, rinsing and sanitizing shall be conducted in the following sequence: sinks shall be cleaned prior to use; equipment and utensils shall be thoroughly washed in the first compartment with hot detergent solution that is kept clean; equipment and utensils shall be rinsed free of detergent and abrasives with clean water in the second compartment; and equipment and utensils shall be sanitized in the third compartment. III This regulation is not met as evidenced by: Class III Please refer to F812.	A7073		
A7076	19 CSR 30-87.030(74) Chemical Sanitization, PPM Measured When chemicals are used for sanitization, they shall not have concentrations higher than the maximum permitted under 21 CFR 178.1010 of the (Revised 2005), Food and Drug Code of the United States Food and Drug Administration, Department of Health and Human Services, and a test kit or other device that accurately measures the parts per million concentration of the solution shall be provided and used. III This regulation is not met as evidenced by: Class III	A7076		

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	07798	A. BUILDING: _____ B. WING _____	08/14/2024

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A7076	Continued From page 7 Please refer to F812.	A7076		
A7077	19 CSR 30-87.030(75) Dishwashing Machine Types Cleaning and sanitizing may be done by spray-type or immersion dishwashing machines or by any other type of machine or device if it is demonstrated that it thoroughly cleans and sanitizes equipment and utensils. In a facility with a licensed capacity of twelve (12) or fewer beds, a home-type dishwashing machine shall be acceptable. If a new machine is purchased, it shall be one with sanitizing capabilities. In a facility licensed for a larger capacity, if a dishwasher is used, it shall meet the requirements in sections (72)-(74) of this rule. Machines and devices shall be properly installed and maintained in good repair; shall be operated in accordance with manufacturers ' instructions; and utensils and equipment placed in the machine shall be exposed to all dishwashing cycles. Automatic detergent dispensers, wetting agent dispensers and liquid sanitizer injectors, if any, shall be properly installed and maintained. II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to the extent of the violation. 1. Refer to F812	A7077		
A7083	19 CSR 30-87.030(81) Machine Chemical Sanitization, PPM Measured	A7083		

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	07798	A. BUILDING: _____ B. WING _____	08/14/2024

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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) COMPLETE DATE
A7083	Continued From page 8 Machines (single-tank, stationary-rack, door-type machines and spray-type glass washes) using chemicals for sanitization may be used provided that-the temperature of the wash water is not less than one hundred twenty degrees Fahrenheit (120°F), the wash water is kept clean, chemicals added for sanitization purposes are automatically dispensed; utensils and equipment are exposed to the final chemical sanitizing rinse in accordance with manufacturers ' specifications for time and concentration, the chemical sanitizing rinse water temperature is not less than seventy-five degrees Fahrenheit (75°F) nor less than the temperature specified by the machine ' s manufacturer; chemical sanitizers used shall meet the requirements of 21 CFR 178.1010 (Revised 2005), Food and Drug Code of the United States Food and Drug Administration, Department of Health and Human Services and a test kit or other device that accurately measures the parts per million concentration of the solution is available and is used. II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to the extent of the violation. Please refer to F812	A7083		
A7088	19 CSR 30-87.030(86) Store Equip/Utensils to Prevent Contamination Cleaned and sanitized utensils and equipment shall be stored above the floor in a clean, dry location in a way that protects them from contamination by splash, dust and other means.	A7088		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07798	A. BUILDING: _____ B. WING _____	08/14/2024

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

(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) COMPLETE DATE
A7088	Continued From page 9 The food-contact surfaces of fixed equipment shall also be protected from contamination. III This regulation is not met as evidenced by: Class III Please refer to F812.	A7088		
A7089	19 CSR 30-87.030(87) Glasses/Cups/Utensils Storage Glasses and cups shall be stored inverted. Other stored utensils shall be covered or inverted, wherever practical. Facilities for the storage of knives, forks and spoons shall be designed and used to present the handle to the employee or consumer. Unless tableware is prewrapped, holders for knives, forks and spoons at self-service locations shall protect these articles from contamination and present the handle of the utensil to the consumer. III This regulation is not met as evidenced by: Class III 1. Please refer to F812	A7089		
A8023	19 CSR 30-88.010(23) Develop/Implement A/N Policies The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of any resident and misappropriation of resident property and funds, and develop and implement policies that require a report to be made to the department for any resident or to both the department and the Department of Mental Health for any vulnerable person whom the administrator or employee has	A8023		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	07798	A. BUILDING: _____ B. WING _____	08/14/2024

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

(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) COMPLETE DATE
A8023	Continued From page 10 reasonable cause to believe has been abused or neglected. II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to the extent of the violation. Refer to F607	A8023		
A8036	19 CSR 30-88.010(35) Activities-Res Choice Each resident shall be permitted to participate, as well as not participate, in activities of social, religious, or community groups at his/her discretion, both within the facility, as well as outside the facility, unless contraindicated for reasons documented by physician in the resident ' s medical record. II/III This regulation is not met as evidenced by: Class II* *The higher classification merited due to the extent of the violation. Refer to F679	A8036		

PLAN OF CORRECTION

Provider/Supplier Name:	Sunset Home
Street Address, City, Zip:	1201 S. Polk Street, Maysville, Missouri 64469
Date of Survey:	08/12/2024

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	

ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION: (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	This Plan of Correction (POC) is submitted as required under State and Federal Law. This submission of the POC does not constitute an admission on the part of Sunset Home, ("the facility") as to the accuracy of the surveyor findings, nor the conclusions drawn there from. The facility's submission of the POC does not constitute an admission on the part of the facility that the findings cited are accurate, or that the scope and severity regarding the deficiencies cited are correctly applied. This POC is intended to constitute the Facility's credible letter alleging compliance. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction.	
F578	**Request/Refuse/Discontinue Treatment; Formulate Advanced Directive** The facility does and will continue to ensure that it accurately displays the residents' correct code status in the resident's medical record and that the code status matches in all areas of the resident's medical record. R# 28 &185's code status was clarified with the resident and responsible party and updated in physical chart, electronic chart, and outside of door. All residents have the potential to be affected by this deficient practice. Nursing staff were provided an educational in-service by the Quality Assurance (QA) Nurse, the Director of Nursing Services, and designee(s) discussing the advanced directives guidelines and procedures. A 100% audit of all resident charts was performed to ensure all components of a resident's advanced directive/code status were in place. The Social Services Designee or Designee(s) will perform audits weekly x 4 weeks, monthly x 2 months, then as needed to	09/18/24

	ensure that all residents advanced directives and code status is accurately reflected in the resident's chart and care plan. The Social Services Designee or Designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	
F607	**Develop/Implement Abuse/Neglect Policies** The facility does and will continue to ensure that it checks the Nurse's Aide (NA) registry prior to hire; before a prospective employee is allowed to work with the residents, a complete background check will be completed; the facility will not employ an individual who has a finding entered on the state Nurse Aide (NA) registry. Dietary Aide (DA) 'B' was checked on the Nurse Aide (NA) Registry by the Business Office Manager (BOM) or designee and a copy of the report was placed in the employee's personnel file. Nurse's Aide (NA) 'A' was checked on the Nurse Aide (NA) Registry by the Business Office Manager (BOM) or designee and a copy of the report was placed in the employee's personnel file. Director of Nursing (DON) was checked on the Nurse Aide (NA) Registry by the Business Office Manager (BOM) or designee and a copy of the report was placed in the employee's personnel file. All residents have the potential to be affected by this deficient practice. The facility Administrator provided an educational in-service to the Business Office Manager (BOM) and designees on pre-employment registry checks prior to hire. The Business Office Manager or designee(s) completed a 100% audit of all employees for the presence of a current Nurse Aide Registry check. All non-compliance was addressed at the time of discovery. The Business Office Manager or designee(s) will audit all employee personnel files monthly x 3 months, then as needed on an on-going basis to ensure that all employee's Nurse Aide Registry checks are completed as required. Non-compliance will be addressed as it is identified. The Business Office Manager or designee(s) will bring monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee meeting monthly and as needed for review.	09/18/24

	Date of Compliance: September 18, 2024	
F623	**Notice Requirements Before Transfer/Discharge** The facility does and will continue to ensure that it provides residents and/or resident responsible parties with written notice of transfer when a resident is transferred to a local hospital. R # 13 has not had any additional transfers or discharges since the date of survey. R # 14 expired August 14, 2024. All residents have the potential to be affected by this deficient practice. Licensed nurses and Social Services Designee were provided an educational in-service by the facility Administrator, facility Director of Nursing, Quality Assurance (QA) Nurse and designee(s) regarding providing notice before transfer/discharge. The facility Director of Nursing or designee(s) will monitor for discharges and transfers to ensure that appropriate notice of transfer/discharge was completed 3x per week x 4 weeks, 2x per week x 4 weeks, 1x per week x 4 weeks, then as needed to ensure compliance. All non-compliance will be addressed as it is identified. The Director of Nursing or designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	09/18/24
F625	**Notice of Bed Hold Policy Before/Upon Transfer** The facility does and will continue to ensure that is provides notice of the bed hold policy to residents or resident responsible parties before/upon transfer(s). R#13 has not been transferred to the hospital since the date of annual survey. R#14 expired on August 14, 2024. All residents have the potential to be affected by this deficient practice. The Quality Assurance (QA) Nurse, facility Director of Nursing, or Designee(s) provided licensed nurse and Social Services Designee with an in-service on the Bed Hold/Transfer Agreement process. The facility Director of Nursing or Designee(s) will monitor completion of bed holds for transfers 3x per week x 4 weeks, 2x per week x 4 weeks, 1x per week x 4 weeks, then as needed to	09/18/24

	ensure compliance. All non-compliance will be addressed as it is identified. The facility Director of Nursing or Designee will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	
F656	**Develop/Implement Comprehensive Care Plan** The facility does and will continue to ensure that residents have complete, accurate and individualized care plans to address their specific needs. R#30 discharged from the facility on August 17, 2024. R # 2, 13, & 20's care plan was updated to reflect activity preferences. All residents have the potential to be affected by this deficient practice. The facility Director of Nursing/MDS Coordinator was provided an educational in-service by the Quality Assurance (QA) Nurse regarding the development and implementation of a comprehensive care plan for all residents. The facility Director of Nursing/MDS Coordinator or Designee(s) will monitor for implementation of a comprehensive care plan that addresses each resident's individual needs, 2x per week x 4 weeks, 1x per week x 8 weeks, then as needed on an ongoing basis to ensure updates and revisions are made timely. All non-compliance will be addressed as it is identified. The Director of Nursing/MDS Coordinator or Designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	09/18/24
F657	**Care Plan Timing and Revision** The facility does and will continue to ensure that resident care plans are completed and revised timely and that all residents have a care plan meeting scheduled quarterly and as needed with the resident and/or responsible parties. R # 2's care plan was updated to remove the use of weighted silverware. R# 13 is scheduled for a quarterly care plan meeting in October 2024. R# 17 is scheduled for a quarterly care plan meeting in September 2024.	09/18/24

	All residents have the potential to be affected by this deficient practice. The facility Director of Nursing/MDS Coordinator and Social Services Designee were provided an educational in-service by the Quality Assurance (QA) Nurse regarding care plan timing and revisions, and scheduling care plan meetings with residents and their responsible parties. The facility Director or Nursing/MDS Coordinator, Social Services Designee, or designee have begun scheduling care plan meetings for residents according to their MDS schedule and as needed. The facility Director of Nursing/MDS Coordinator or Designee(s) will monitor for necessary changes/revisions needed to the care plan 2x per week x 4 weeks, 1x per week x 8 weeks, then as needed on an ongoing basis to ensure updates and revisions are made timely. All non-compliance will be addressed as it is identified. The Director of Nursing/MDS Coordinator, Social Services Designee or Designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	
F679	**Activities to Meet the Needs and Preferences of Residents** The facility does and will continue to ensure that each resident has an ongoing program to support their choice of activities based on their preferences to meet their interests and support their physical, mental, and psychosocial well-being that encourages both independence and interaction in the community. R's # 2, 13, 17, 20, 21's care plans were updated to reflect their activity preferences. R's # 2, 13, 17, 20, 21 were provided with a monthly activity calendar for their room. All residents have the potential to be affected by this deficient practice. The facility Activities Director (AD), and Director of Nursing/MDS Coordinator and designee(s) were provided an educational in-service by the Quality Assurance (QA) Nurse regarding resident activities including activity scheduling, activity variation, resident activity interviews, activity calendar, documentation of activity progress notes/participation. The facility Activities Director (AD) has performed a 100% review with all current residents to identify their activity preferences and interests.	09/18/24

	All resident's activity care plans were updated by the facility Activity Director, MDS Coordinator and designee(s). The facility Activity Director (AD) or designee(s) will audit residents to ensure activity preferences remain care planned and that residents are invited to activities 2x per week x 4 weeks, 1x per week x 8 weeks, then as needed to ensure ongoing compliance. All non-compliance will be addressed as it is identified. Monitored findings will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed by the facility Activity Director (AD) or designee(s). Date of Compliance: September 18, 2024	
F695	**Respiratory/Tracheostomy Care and Suctioning** The facility does and will continue to ensure that each resident receives necessary respiratory care and services that is in accordance with professional standards of practice, the resident's care plan and the resident's choice. The facility does and will continue to ensure that staff obtain and follow, complete and accurate physician orders for the administration of continuous positive airway pressure (CPAP) machines. The facility does and will continue to ensure that it labels, dates, and cleans continuous positive airway pressure (CPAP) machines for all residents that use them per facility guidelines. The facility does and will continue to ensure that it labels and dates open containers of distilled water for use in all continuous positive airway pressure (CPAP) machines for all residents that use them per facility guidelines. R # 30's discharged from the facility on August 17, 2024. R# 28 had an order for the continuous positive airway pressure (CPAP) machine cleaning added to medical record. R #'s 28 was provided with new bottle of distilled water for use and water bottle was dated with open date and discard date (30 days from open date) upon distribution. All residents who receive respiratory care such as oxygen, CPAP or BiPAP therapies have the potential to be affected by this deficient practice. The Quality Assurance (QA) Nurse and Director of Nursing provided all nursing staff with an educational in-service on respiratory equipment use and cleaning measures. A 100% audit was completed by the Director of Nursing and designee(s) to ensure that all resident's with oxygen, CPAPs,	09/18/24

	etc. have all necessary orders for administration and cleaning in medical record. The Director of Nursing or designee(s) will audit residents with respiratory orders (02, CPAP, etc.) to ensure proper labeling, cleaning, etc. is in place 2x per week x 4 weeks, 1x per week x 8 weeks, then as needed to ensure ongoing compliance. Any non-compliance will be addressed as it is identified. The Director of Nursing or designee(s) will report all monitored findings to the Quality Assurance Performance Improvement (QAPI) committee for review monthly and as needed. Date of Compliance: September 18, 2024	
F699	**Trauma Informed Care** The facility does and will continue to ensure that all residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. R # 30 was discharged from the facility on August 17, 2024. All residents with a history of trauma have the potential to be affected by this deficient practice. The Quality Assurance (QA) Nurse provided the Director of Nursing/MDS Coordinator, Social Services Designee, or designee(s) with an educational in-service regarding the screening, identification and care planning of residents to identify a history of trauma and to properly care plan for the resident's needs. The Director of Nursing/MDS Coordinator, Social Services Designee or designee(s) will ensure all current residents with a history of traumatic event or related diagnosis have care planning to reflect the event/diagnosis. The Director of Nursing/MDS Coordinator or designee(s) will audit all new admissions for the presence of trauma screening and appropriate care planning 2x per week x 4 weeks, then 1x per week x 8 weeks, then as needed to ensure ongoing compliance. Any non-compliance will be addressed as it is identified. The Director of Nursing/MDS Coordinator or designee(s) will report all monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	09/18/24

F700	**Bed Rails** The facility does and will continue to ensure that prior to the installation or use of bed rails, an attempt to use alternatives has been attempted. If the attempted alternatives are not adequate to meet the resident's needs, the resident is assessed for the use of bed rails, which includes a review of risks including entrapment; and informed consent is obtained from the resident or if applicable, the resident representative. The facility will ensure the bed is appropriate for the resident and that bed rails are properly installed and maintained. R # 14 expired on August 14, 2024. R #'s 13 & 20, physician's order for bed rail, informed consent, risk vs. benefits and quarterly rail assessment was updated. R # 21's bed rails were removed due to non-use. All residents with the need for bed rails are at risk for this deficient practice. The facility Administrator, Director of Nursing/MDS Coordinator, Social Services Designee, and Maintenance Director received an in-service from the Quality Assurance (QA) Nurse discussing all elements needed for bed rail use. The Director of Nursing or designee(s) provided licensed nurses with an educational in-service regarding the elements needed for bed rail use. The Director of Nursing and designee(s) completed a 100% audit of all residents for the presence of all elements needed for appropriate bed rail use including: physician's orders, informed consent, care plan, documentation of risk v. benefit. Non-compliance was addressed at the time it was identified. The Director of Nursing or designee(s) will audit all new admissions for the need for bed rails and to ensure all elements are in place for proper bed rail usage and documentation 2x week x 4 weeks, weekly x 8 weeks, then as needed to ensure ongoing compliance. Any non-compliance will be addressed as it is identified. Going forward, compliance will be maintained through the following actions: **New admissions** will be checked upon admission to ensure that side rail assessment, including informed consent, physician's order, documentation of discussion with resident and/or responsible party regarding risks vs. benefits of side rail use, and appropriate care planning is in place for all side rail use. **Existing residents** will be checked quarterly with MDS schedule and as needed for any changes to ensure the presence of an updated/current side rail assessment,	09/18/24

	documentation of discussion w/ resident and/or responsible party regarding risks vs. benefits of side rail use, physician's order, and updated care plan are in place accurately reflecting side rail use. The Director of Nursing or designee(s) will report all monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	
F726	**Competent Nursing Staff** The facility does and will continue to ensure that it provides competency assessments in accordance with the facility assessment and as needed. The facility assessment was updated to reflect nurse aide competency completion frequency to upon hire, annually, and as needed – not every 6 months as previously written. Employee's A, C, E, F, were provided with annual competency training. Employee B is no longer scheduled in the nursing department. Employee's D and G are no longer employed with the facility. Education has and will be provided by the Quality Assurance (QA) RN, the facility Director of Nursing, and designee(s) regarding nursing competency requirements and completion schedules. All residents have the potential to be affected by this deficient practice. The facility Director of Nursing or Designee(s) ensure all employees have completed the required competencies and will continue to ensure that all newly hired staff receive the required competency training when hired. This will be monitored monthly x 3 months to ensure that all education requirements are met and maintained. All non-compliance will be addressed at the time it is identified. The facility Director of Nursing or Designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	09/18/24
F727	**RN 8 Hours/Day, 7 Days/Week** The facility does and will continue to ensure that a Registered Nurse (RN) is on duty 8 consecutive hours per day, 7 days per week.	09/18/24

	All residents have the potential to be affected by this deficient practice. The facility has recently increased hiring wages for Registered Nurses and continues to advertise for open RN positions. The facility has applied to renew the Registered Nurse (RN) staffing waiver with CMS; approval of waiver is pending as of September 6, 2024. The Quality Assurance (QA) Registered Nurse provided the Director of Nursing/MDS Coordinator and facility Administrator with an educational in-service regarding RN coverage requirements. The facility Director of Nursing and facility Administrator will ensure that a Registered Nurse (RN) is on duty for a minimum of 8 consecutive hours per day, 7 days per week, when managing the nursing department schedule. The Director of Nursing or designee(s) will audit the nursing schedule 2x per week x 4 weeks, 1x per week x 8 weeks, then monthly as needed to ensure ongoing compliance with RN coverage requirements. Any non-compliance will be addressed as it is identified. The Director of Nursing or designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024.	
F728	**Facility Hiring and Use of Nurse Aide** The facility does and will continue to ensure that all nurse aides complete the nurse aide training program within four months (120 days) of his/her employment in the facility. Nurse Aide A's annual competencies will be updated by September 18, 2024. Nurse Aide 'A' received certification and is now a Certified Nurse Assistant effective May 24, 2024. Nurse Aide B will not be scheduled in the nursing department until her certification is obtained. The facility Director of Nursing and facility Administrator was provided with an educational in-service regarding the hiring and use of nurse aides by the Quality Assurance (QA) RN. The facility Director of Nursing or Designee(s) will monitor all uncertified nurse aide's hire dates to ensure they're certified within 120 days of hire. This will be monitored monthly x 3 months, then as needed to ensure ongoing compliance.	09/18/24

	The facility Director of Nursing or designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	
F730	**Nurse Aide Performance Review/12 Hour In-service** The facility does and will continue to ensure that a performance review of every nurse aide is completed at least once every 12 months, and that every nurse aide is provided with regular in-service education based on the outcome of these reviews. All residents have the potential to be affected by this deficient practice. The Director of Nursing and Business Office Manager reviewed all current nurse aide employee files for hire date; current nurse aides who are past due for an annual performance review were scheduled with the Director of Nursing for an annual performance review. Nurse aides who are not yet due for an annual performance review will be scheduled when the performance review is due, around the anniversary of their date of hire. The Director of Nursing, facility Administrator, and designee(s) were provided an in-service on annual performance review scheduling and completion, annual nurse aide education requirements and competencies by the Quality Assurance Nurse. The Director of Nursing, or Designee(s) will audit new employee files monthly x 3 months, then as needed on an ongoing basis to ensure ongoing compliance. Any non-compliance will be addressed as it is identified. The Director of Nursing, or Designee(s) will report monitored findings to the Quality Assurance Performance Improvement Committee monthly and as needed for review. Date of Compliance: September 18, 2024	09/18/24
F804	**Nutritive Value/Appear, Palatable/Prefer Temp** The facility does and will continue to ensure that all food served to the residents is palatable, attractive, served at a safe and appetizing temperature. R #'s 2, 13, 21, 185 have not had any further complaints to dietary and/or administrative staff regarding food upon interview. All residents have the potential to be affected by this deficient practice. Dietary staff were provided an educational in-service by the facility Administrator.	09/18/24

	The Dietary Services Manager or designee(s) will audit temperature of food prior to serving for 2 meals per day, 3 days per week x 4 weeks, then one meal per day, 3 days per week x 4 weeks, then one meal per week x 4 weeks, then as needed to ensure ongoing compliance. The Dietary Services Manager or designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly and as needed for review. Date of Compliance: September 18, 2024	
F812	**Food Procurement, Storage, Prep, Serve-Sanitary** The facility does and will continue to ensure that it prepares, stores, and serves food in accordance with professional standards for food service safety. All residents have the potential to be affected by this deficient practice. Dietary department staff were provided an educational in-service by the facility Administrator and Dietary Services Manager (DSM) regarding food procurement, storage, preparation, serving, and sanitation requirements. The Dietary Services Manager (DSM) will audit for the presence of: 1. Dietary department cleaning schedule - DSM or designee(s) will monitor that dietary cleaning schedule is followed 2 x weekly x 4 weeks, weekly x 8 weeks, then as needed to ensure ongoing compliance 2. Monitoring fridge/freezer temperatures daily - DSM or designee(s) will monitor that fridge and freezer temps are being checked daily 2x weekly x 4 weeks, weekly x 8 weeks, then as needed to ensure ongoing compliance 3. Monitoring dishwasher sanitization daily - DSM or designee(s) will monitor dishwashing sanitization completion 2x weekly x 4 weeks, weekly x 8 weeks, then as needed to ensure ongoing compliance 4. Sanitizing kitchen food prep surfaces - DSM or designee(s) will monitor food prep surface sanitization completion 2x weekly x 4 weeks, weekly x 8 weeks, then as needed to ensure ongoing compliance 5. Handwashing - DSM or designee(s) will monitor handwashing completion 2x weekly x 4 weeks, weekly x 8 weeks, then as needed to ensure ongoing compliance 6. Storage and labeling of food items - DSM or designee(s) will monitor storage and labeling of food items 2x weekly x 4 weeks, weekly	09/18/24

	x 8 weeks, then as needed to ensure ongoing compliance 7. Monitoring food serving temperatures - DSM or designee(s) will monitor food temperatures 2x weekly x 4 weeks, weekly x 8 weeks, then as needed to ensure ongoing compliance Any non-compliance will be addressed as it is identified. The Dietary Services Manager (DSM) or designee will report monitored findings to the Quality Assurance Performance Improvement Committee for review monthly and as needed to ensure ongoing compliance. Date of Compliance: September 18, 2024	
F921	**Safe/Functional/Sanitary/Comfortable Environment** The facility does and will continue to ensure that it provides a safe, functional, sanitary, and comfortable environment for residents, staff and the public. An outside plumbing vendor was contacted by the facility Maintenance Director regarding installation of a shower backflow preventer device. The necessary part was ordered by the outside plumbing vendor on September 4, 2024. An outside plumbing vendor will install the shower backflow preventer device after the part arrives. All residents have the potential to be affected by this deficient practice. The Maintenance Director will report any further findings to the Quality Assurance Performance Improvement Committee for review. Date of Compliance: September 18, 2024	09/18/24
F925	**Maintains Effective Pest Control Program** The facility does and will continue to ensure that it maintains an effective pest control program so that the facility is free of pests and rodents. Spiders were eradicated from the sprinkler riser room August 30, 2024 by an outside pest control vendor. There have not been any reported sightings of gnats present in the facility since survey exit. All residents have the potential to be affected by this deficient practice. The facility Maintenance Director received an in-service on maintaining an effective pest control program from the facility Administrator.	09/18/24

	Staff received an in-service from the facility Administrator and designee(s) regarding identification and reporting of pests per facility guidelines. The facility Maintenance Director or designee(s) will make 'Pest Control' rounds to monitor for and remove any pests 2x week x 4 weeks, weekly x 8 weeks, then as needed to ensure ongoing compliance. All non-compliance will be addressed as it is identified. The facility Maintenance Director or designee(s) will report monitored findings monthly and as needed to the Quality Assurance Performance Improvement Committee for review. Date of Compliance: September 18, 2024	
F947	**Required In-Service Training for Nurse Aides** The facility does and will continue to ensure that it develops, implements, and permanently maintains an in-service training program for nurse aides that is appropriate and effective, as determined by the nurse aide performance reviews, the facility assessment, changes to the facility's resident population, the facility's physical environment, staff turnover and any other relative factors that may necessitate ongoing changes to the facility's training program. All residents have the potential to be affected by this deficient practice. The Quality Assurance (QA) Nurse provided the facility Director of Nursing and facility Administrator with an educational in-service regarding the requirement for 12-hour in-service training for nurse aides. The Director of Nursing and designee(s) provided nursing staff with an educational in-service related to nurse aide in-service requirements. An all-staff in-service is scheduled for September 10, 2024. The Director of Nursing or designee(s) performed an audit of the current nurse aide in-service logs to identify each nursing employee's educational in-service needs. Non-compliance was and will be addressed as it was identified. The facility Director of Nursing and/or designee(s) will audit the required in-service log for completion of required in-service education items weekly x 4 weeks, then monthly x 2 months, then then as needed on an ongoing basis to ensure ongoing compliance. Any non-compliance will be addressed as it is identified. The Director of Nursing or Designee(s) will report monitored findings to the Quality Assurance Performance Improvement (QAPI) committee monthly and as needed for review.	09/18/24

	Date of Compliance: September 18, 2024	
A4103	**Activities – Advanced Notification** Please refer to F679 Date of Compliance: September 18, 2024	09/18/2024
A4113	**Progress Notes – Transfer/Discharge** Please refer to F623 Please refer to F625 Date of Compliance: September 18, 2024	09/18/24
A6028	**Backflow Requirements** Please refer to F921 Date of Compliance: September 18, 2024	09/18/24
A6031	**Kitchen Waste Containers Covered** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A6039	**Insect/Rodent Control** Please refer to F925 Date of Compliance: September 18, 2024	09/18/24
A6044	**Hand-Cleansing Soap/Towels Available** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7002	**Wash Hands/Arms & Clean Fingernails** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7034	**Metal Steam-Type Thermometers Used** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7036	**Food-120 Degrees/Above, 45 Degrees/Below** Please refer to F804 Date of Compliance: September 18, 2024	09/18/24
A7066	**Grills/Griddles/Microwaves/Other-Clean Daily** Please refer F812 Date of Compliance: September 18, 2024	09/18/24
A7067	**Nonfood Contact Surfaces Cleaned as Needed** Please refer to F812	09/18/24

	Date of Compliance: September 18, 2024	
A7068	**Cloths for Food Service Only, Clean & Dry** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7069	**Moist Cloth-Kitchenware/Equip Clean/Sanitize** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7070	**3 Compartment Sink-Wash/Rinse/Sanitize** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7073	**Equipment Cleaning Sequence in Sink** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7076	**Chemical Sanitization, PPM Measured** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7077	**Dishwashing Machine Types** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7083	**Machine Chemical Sanitization, PPM Measured** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7088	**Store Equipment/Utensils to Prevent Contamination** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A7089	**Glasses/Cups/Utensils Storage** Please refer to F812 Date of Compliance: September 18, 2024	09/18/24
A8023	**Develop/Implement A/N Policies** Please refer to F607 Date of Compliance: September 18, 2024	09/18/24
A8036	**Activities – Res Choice** Please refer to F679	09/18/24

	Date of Compliance: September 18, 2024	

The Administrator signing and dating the first page of the CMS-2567/State Form is indicating their approval of the plan of correction being submitted on this form.