STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145800	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Home	418 Washington Street Quincy, IL 62301

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0580

Level of Harm - Actual harm

Residents Affected - Few

Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 30224

Based on interview and record review, the facility failed to notify the physician of a significant change in condition for one of three residents (R4) reviewed for change in condition in the sample of ten. These failures resulted in R4 being diagnosed with a Severe Urinary Tract Infection (UTI), Sepsis, and being hospitalized for five days.

Findings include:

The Facility's Change in a Resident's Condition or Status policy dated 12/18/23, states Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status. 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician in a timely manner when there has been: a. An accident or incident involving the resident; b. A discovery of injuries of an unknown source; c. A reaction to medication; d. A significant change in the resident's physical/emotional/mental condition; e. A need to alter the resident's medical treatment significantly; f. Refusal of treatment or medications (two or more consecutive times); g. A need to transfer the resident to a hospital/treatment center; h. A discharge without proper medical authority; and/or i. Instructions to notify the physician of changes in the resident's condition. 2. A significant change of condition is a decline or improvement in the resident's status that: a. Will not normalyl resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. 3. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative when: b. There is a significant change in the resident's physical, mental, or psychosocial status. 4. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. 6. The Nurse Supervisor/Charge Nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition/status.

R4's electronic medical record documents R4 was admitted to the facility on [DATE] and discharged to the hospital on 3/15/24. R4 was admitted with diagnoses which included but not limited to, Nontraumatic Intracerebral Hemorrhage, Dementia with Altered Mental Status, History of Urinary Tract Infections, and Urinary Retention.

R4's Minimum Data Set assessment dated [DATE], documents R4 had severely impaired cognition and was frequently incontinent of bowel and bladder.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145800	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER Sunset Home		STREET ADDRESS, CITY, STATE, ZIP CODE 418 Washington Street Quincy, IL 62301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0580

Level of Harm - Actual harm

Residents Affected - Few

R4's Admission Progress Note dated 2/7/24, documents R4 was admitted to the facility on an antibiotic medication for a diagnosis of Urinary Tract Infection (UTI).

R4's Progress Note dated 3/9/24 at 1:49 p.m., written by V20 (Licensed Practical Nurse/LPN), documents 600 milliliters (ml) of urine was drained via straight catheterization; R4's urine had a foul odor and had mucus discharge.

R4's Progress Notes dated 3/9/24 do not document that R4's physician was notified of her abnormal urinary symptoms.

R4's Progress Notes dated 3/10/24 at 4:14 p.m., written by V20, states Straight cathed (catheterized) (R4) per sterile technique, 500 (milliliters) immediate return of foul-smelling urine. At the end of draining again was thick mucus, foul strong odor, so thick it had difficulty draining through the tube.

R4's Progress Note dated 3/15/24 at 12:12 p.m., states (V27/R4's family) called insisting that (R4) is sent to the (emergency room) for potassium. (V27) stated he has seen this before and she is need of this. This same progress note documents R4's physician/nurse practitioner was notified, and orders were received to send R4 to the hospital via ambulance.

R4's Hospital Records dated 3/15/24, document R4 was admitted to the hospital with diagnoses of Severe Urinary Tract Infection, Sepsis, and Metabolic Encephalopathy. These same hospital records document R4 was discharged to another facility on 3/20/24.

On 4/2/24 at 10:57 a.m., V27 (R4's family) stated he had noticed R4 had a decline in her overall condition a week or so before she was sent to the hospital (on 3/15/224). V27 stated he would try to talk to staff about R4's condition and they blew me off and thought I didn't know what I was talking about. V27 stated I had even talked to (V18/Physical Therapist) on 3/14/24 and V18 thought R4 was being treated with an antibiotic for a UTI. Come to find out she was not on an antibiotic and that is how she ended up so sick and hospitalized on [DATE]. If they had reported her symptoms and decline sooner, she wouldn't have gotten so bad. V27 stated on 3/15/24, he went to visit R4 before lunch and she didn't respond to V27 like she normally would. V27 stated he lifted her head up while she was sitting in her wheelchair, and it was limp. V27 stated one of the staff members sitting in the dining room stated R4 had just gotten up and was not in a good mood. V27 stated he was so upset at the lack of concern for R4's poor condition that he had to leave the building and go sit in his truck and call R4's nurse to tell her to send R4 to the hospital. V27 stated I think it was (V20/LPN) that I told about (R4) needing to go to the hospital because something was wrong. (R4) has had potassium level issues in the past and has acted like she was that day. I knew she wasn't right, and they were just acting like she was just tired. I told (V20) that I wanted to talk to the Unit Coordinator (V17) so I could tell her what was going on and that no one was doing anything for (R4). It wasn't a few minutes later that I received a text message from (V17) telling me they called an ambulance to take (R4) to the hospital. She was so sick by the time she got to the hospital with a UTI that she had become septic and had metabolic Encephalopathy. If they had treated her sooner with an antibiotic, she wouldn't have been so sick.

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NAME OF PROVIDER OR SUPPLIER: Sunset Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 418 Washington Street Quincy, IL 62301	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Actual harm Residents Affected - Few	On 4/2/24 at 2:35 p.m., V2 (Director of Nursing) stated there is no documented evidence that R4's physician or nurse practitioner were notified of R4's abnormal urine (foul odor and mucous) that was first documented on 3/9/24. V2 stated R4's physician should have been notified of that change in condition. V2 stated R4 ended up hospitalized with diagnoses of UTI, Sepsis, and Metabolic Encephalopathy. On 4/3/24 at 10:09 a.m., V20 (Licensed Practical Nurse) stated R4's progress notes dated 3/9/24 and 3/10/24 were both shifts that V20 noticed R4's abnormal urine output during a straight catheterization procedure. V20 stated she recalls the urine having a foul odor and very thick mucus. V20 stated V20 did not notify R4's physician or nurse practitioner according to R4's progress notes. V20 stated I was working on 3/15/24 when (V27) called and said R4 needed to be sent to the hospital because he thought she needed some potassium by the decline in her condition. I reported this information to (V17/Unit Coordinator) who took over from there and had R4 sent to the emergency room . (R4) ended up being septic from a UTI if I remember correctly. On 4/3/24 at 11:13 a.m., V36 (R4's Nurse Practitioner) stated Anytime we get a call or fax from a nursing home our secretaries put a note in our computer system so we can see what is going on with the residents at all times. There is nothing documented in (R4's) record that we were notified of foul odor or purulent drainage in (R4's) urine. She was feisty with the staff during cares, but she had moments that she was alert and would eat or drink. I personally witnessed the family giving her food and drinks when they visited. If I would have been notified of R4's signs of a UTI I would have ordered a UA (Urinalysis) and started her on an antibiotic while we waited on the culture results. I am confident that (V37/Nurse Practitioner) would have ordered a urinalysis and antibiotic if she knew about (R4's) signs and symptoms of a UTI. If (R4) had been treated when her infection symptoms first started, it's very unlikely that she would have been admitted to the hospital with a severe UTI and sepsis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30224 Based on observation, interview, and record review, the facility failed to provide supervision to a resident with severely impaired cognition and a known wanderer, failed to respond to door alarms at the door and at the main alarm panel, and failed to thoroughly investigate an elopement for one of three residents (R1) reviewed for accidents in the sample of ten. These failures resulted in R1, a severely cognitively impaired resident with a diagnosis of Dementia, eloping from her unit through an open double door that is normally closed, approximately 80 feet, to an unoccupied area of the building, getting through an alarmed door that leads to a stairway and being found on a landing after descending 8 steps. R1's wheelchair was tipped backwards in front of her on the landing. These failures resulted in an Immediate Jeopardy. While the immediacy was removed on 4/2/24, the facility remains out of compliance at a severity Level II as additional time is needed to evaluate the implementation and effectiveness of their Removal plan and Quality Assurance monitoring. Findings include: The Facility's Safety of Residents/Procedure for Missing Residents policy (undated), states A light panel on 2 Riverview Nursing station will indicate if a door alarm has been activated. This includes internal doors with alarms as well as outside doors with alarms. A staff member will be dispatched to check out the alarm. After staff member reaches the alarmed door and assesses the situation, they will return to the unit to discuss with charge nurse or house supervisor. The alarm is to stay on until staff has checked the reason for the door alarm. On 3/29/24 at 11:10 a.m., R1 was observed up in her wheelchair and independently propelling the wheelchair with her feet. R1 was confused and visiting with peers and staff. R1's current electronic medical record, documents R1 is an [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included but not limited to, Dementia without behavioral disturbances, History of Falls with Fractures, Age-Related Osteoporosis, Hypertension, Long-Term use of Anticoagulants, Major Depressive Disorder, and Protein-Calorie Malnutrition. R1's Minimum Data Set assessment dated [DATE], documents R1 has severely impaired cognition; has a behavior of wandering on a daily basis; requires substantial/maximal assistance with transfers; is unable to ambulate; and propels wheelchair independently with supervision. R1's current Care Plan states, (R1) moves about the unit in her (wheelchair) at times going in and out of other's rooms; this occurs daily most of the time; (R1) is usually easily redirected; (R1) has dementia and will get self-up and down from chair, bed, etcetera, repeatedly at times. She does not remember to ask for assist. Restless movements occur daily. On 3/29/24, R1's Care Plan had not been updated to reflect R1's elopement on 2/23/24 or R1's increased risk for elopement and interventions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Incident Report dated 2/23/24 at 5:00 p.m., completed by V6 (Licensed Practical Nurse/LPN) states (V6) came up to the nurse's station to pass 4:00 p.m. medications around 4:35 p.m. (R1) was wandering around the nurse's station and talking to others. (V6) noticed around 4:50 p.m. (that R1) was no longer around and I had medication to give her. (V6) asked the (Certified Nurse Aides/CNA's) if they knew where (R1) was and they said, she was just right here and that they didn't know where she was. (V6) checked the dining room and resident's room, (R1) was not present. (V6) alerted other staff on unit that (R1) was missing. Between myself (V6), CNAs, and other nurse on duty we looked in all of the other resident's rooms and bathrooms, the shower room, dining room and 4 City View (adjoining unit that is not occupied). (R1) was not in any of those places. We continued to look for (R1). (V6) returned to the nurse's station. (V5/LPN) called the (second floor nurse's station) to ask if any of the stairwell alarms had gone off recently and was told 'no.' (V5) went to continue searching for (R1). (V5) returned to (R1's unit/4 River View) only a couple of minutes later and said that she needed help and that she found (R1). This nurse (V6) immediately followed (V5) and told the CNAs to call 911. (R1) was observed at the bottom of the stairs on 4 (City View South). (R1) was sitting on the bottom stair and wheelchair was to her right and the wheelchair was tipped over on its back wheels. (R1) denied injury but stated her left leg hurt. (R1) was attempting to move herself and get up. (V6 and V5) advised (R1) to not move. (R1) could not say how she got there. The facility's investigation of R1's Elopement dated 2/28/24, does not document any information regarding the staffs' lack of response to the door alarm sounding where R1 exited from or the main door alarm panel at the time of R1's elopement on 2/23/24. R1's medical record does not document an updated Elopement Risk Assessment was completed after R1's elopement on 2/23/24. On 3/28/24 at 10:10 a.m., V2 (Director of Nursing) stated on 2/23/24, R1's nurse could not find R1 to give her 4:00 p.m. medications. V2 stated all staff immediately started searching for R1. V2 stated there was a period of approximately 10-15 minutes when R1's location was not known. V2 stated staff found R1 and her wheelchair in a stairwell on the south side of the adjoining unit. V2 stated I have no idea how she got down that set of steps. Her wheelchair was next to her tipped over. V2 stated an alarm has been added to the set of double doors that leads to R1's adjoining unit. V2 stated R1 had a small bruise above her left eye but was sent to the local hospital for evaluation and returned with no new injuries. V2 stated R1 has a history of falls with fractures, and she was shocked that R1 had no fractures from this incident on 2/23/24. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/28/24 at 1:44 p.m., V8 (Certified Nurse Aide) stated she was working the evening that R1 was missing and found at the bottom of the stairwell. V8 stated R1 was found on the fourth floor on the unit 4 City instead of R1's unit 4 Riverview. V8 stated 4 City View is unoccupied and no one was in that area at the time of R1's elopement on 2/23/24. V8 stated R1 was on the move (2/23/24) and wanting to go somewhere. V8 stated She wanders constantly when she is in her wheelchair, but she stays close to us because she likes to visit. She thought there was dinner that needed to be cooked. She had increased behaviors that day. She thought the kids were waiting on her. She wanders up and down the halls and goes in other resident rooms, so we have to keep an eye on her. We try to keep her occupied with food and activities. I'm not sure who saw her last. I wasn't on the floor when they realized she was missing. When I came back up, they said they couldn't find (R1). I don't think it was very long before they missed her. We are always watching for her. She can walk short distances if she is in the right mood. When I went to the stairwell, I saw the wheelchair at the bottom flipped backwards and she was sitting on the bottom step trying to get herself up. She kept saying she wasn't hurt; she was just trying to get up. (R1) had no injuries other than a small bump over her eye. No bleeding or obvious fractures. On 3/29/24 at 9:10 a.m., V5 (Licensed Practical Nurse) stated she was working on R1's unit (4 Riverview) on 2/23/24 when R1 eloped from the unit. V5 stated she did not hear any alarm sound on the door that R1 opened and descended to the bottom of the stairs to the first landing. V5 stated I had just talked to (R1) up by the nurse's station and then went on to finish my medication pass. I heard staff looking for (R1) and I immediately assisted in the search. We looked everywhere on the unit and then went over to 2 City View (the adjoining unit that is not occupied) and also sent staff to other floors to look for her. I finally went to the 4 south stairwell and found her and went to get help. After we got (R1) sent to the emergency department for evaluation, I called down to the nurse on second floor V14/Licensed Practical Nurse) that has the door alarm panel for the entire facility. At first, she told me that she silenced an alarm that she thought was the back door. I proceeded to inform her that (R1) had gotten down the 4 south stairwell and we did not hear an alarm and ask her why she didn't call us to see what was going on. (V14) then changed her story and said she had not silenced any alarms. The door alarm was working so I know that is what happened. We just couldn't hear the alarm. Had she called to check on the door alarm we would have found (R1) quicker. I did not have anyone from administration question me about the door alarms. On 3/29/24 at 9:30 a.m., V1 (Administrator) stated she was aware of R1's elopement on 2/23/24 but she did not assist V2 with the investigation or know of any issues with the alarms being silenced at the main panel. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/29/24 at 9:40 a.m., V6 (Licensed Practical Nurse) stated she was R1's nurse on 2/23/24. V6 stated I remember seeing (R1) sometime between 4:30-4:45 p.m. after the (Certified Nurse Aides) got her out of her recliner and into her wheelchair for supper. We had a resident on the unit that was actively dying, and I had gone to check on that resident. When I came back up by the nurse's station (R1) wasn't up there. My first thought was the staff must have already taken (R1) to the dining room for supper. I continued to pass more medications. I remember asking a couple of the (Certified Nurse Aides) if (R1) was in the dining room and they told me she was not in the dining room. I started checking other resident rooms because it is not uncommon for (R1) to go into other resident rooms. She was nowhere to be found. We checked 4 City View (adjoining unoccupied unit) because the double doors that separates the two units had been open all day. Those double doors are usually shut. All staff on unit were searching the entire facility for her. We did not receive any calls from second floor staff to say we had an alarm sounding that needed to be checked. (V5) finally found (R1) down the first set of stairs of the 4-south stairwell. The alarm was working when we went to go assess her. I have no idea how (R1) got down those stairs, but she had no major injuries. Her wheelchair was sitting on its back in front of her, so I believe it went down first. I don't think she was in it, or she wouldn't have been sitting on the stairs. She couldn't have climbed over the wheelchair. She can't walk much but I wonder if she held on to the railing and scooted or walked down the steps. We will never know because she has no memory of the incident. She had a small bruise over her eye and no other noted injuries, but we kept her there until the ambulance came to get her in case, she had internal injuries or fractures. She came back with no major injuries noted at the emergency room . No one from administration interviewed me about this elopement. No one asked anything about the door alarms. On 3/29/24 at 10:15 a.m., V14 (Licensed Practical Nurse) stated she was working on 2/23/24 when R1 went missing and was later found in the stairwell. V14 stated the main panel for all facility door alarms, is located at the second-floor nurse's station. V14 stated when an alarm is activated it sounds on the panel and the location of the door is identified. V14 stated usually staff clear the door and the alarm panel shuts off with no action from second floor staff. V14 stated if for any reason a door alarm continues to sound the second-floor staff are supposed to call the identified unit on the alarm panel and tell them there is an alarm sounding and ask if all residents are accounted for. V14 verified that the second-floor staff are not supposed to turn the alarm on the panel off until they receive an all clear from the unit assessing the door alarm. V14 stated around the time that R1 went missing on 2/23/24, V14 recalls an alarm going off for 5-10 minutes and she was trying to listen for her own unit residents, so she silenced the alarm on the main panel. V14 stated I thought it was the back door that was going off, so I didn't call anyone. Once the alarm is silenced the door will reset and stop alarming. V14 stated after R1's staff had found R1, one of the nurses on R1's unit called and asked about the alarm sounding but I couldn't see for sure what door was alarming. V14 stated No one from administration interviewed me or in-serviced me on door alarms and elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 3/29/24 at 11:33 a.m., V9 (Certified Nurse Aide) stated V9 was working R1's unit when she eloped on 2/23/24. V9 stated R1 is usually around the nurse's station and talking to everyone. V9 stated I had gotten everyone down to the dining room for supper and we all realized (R1) was not in sight. We searched everywhere for her. 4 City View is the unit adjoining 4 Riverview (R1's unit) and it is currently not occupied. The double doors that separate these two units are always kept closed but it is not alarmed. For some reason, it was open on day shift. I don't know who opened them up. They are able to stay open with the magnets on the wall. Finally, one of us said we needed to check the stairwells. I did not hear an alarm sound but the alarm on the door she went through was working because it sounded when we went through it to find her. The staff from the second floor have the main panel for all the alarms. They are supposed to call us if we have an alarm sounding and they didn't do that. I think it was shut off on the second floor, so we never did hear it. On 3/29/24 at 11:40 a.m., V2 (Director of Nursing) stated through her investigation of R1's elopement on 2/23/24, she did not identify any issues regarding door alarms. V2 stated she did not educate/in-service staff on elopement or door alarms. The Immediate Jeopardy was identified to have started on February 23, 2024, when the facility failed to provide adequate supervision to R1 to prevent her from eloping from her unit and failed to respond to door alarms heard at the main alarm panel around 4:45 p.m., resulting in R1 being found approximately 80 feet away from her unit, to a unoccupied area of the building, getting through an alarmed door that leads to a stairway and being found on a landing after descending 8 steps. V2 (Director of Nursing/DON) was notified of the Immediate Jeopardy on 4/1/24 at 12:45 p.m. The surveyor confirmed through observation, interview, and record review that the facility took the following actions to remove the Immediate Jeopardy: 1. All facility staff were educated by V2 on the facility's Safety of Residents policy and the facility's door alarm system including the importance of not silencing/shutting off the alarm at the main panel until the alarm has been assessed by staff and clearance is received to shut the alarm off. 2. V2 (Director of Nursing) submitted an addendum to the investigation report regarding R1's elopement after a more thorough investigation was completed. 3. V1 (Administrator) and V2 (Director of Nursing) were in-serviced by V46 (Human Resources) on completing a thorough investigation. 4. V2 (Director of Nursing) updated R1's elopement risk/interventions and updated R1's elopement care plan. 5. All residents currently assessed at high risk for elopement risk were reviewed for Care Planned interventions and identifying information in the elopement binder. All newly assessed high risk individuals will be added to the facility elopement binder and have this risk addressed in their Care Plans. 6. The facility will complete ongoing monitoring through the quarterly QAPI process.