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 08/12/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 33970 Based on record review and interview the facility failed to document and address a grievance for one resident (R3) of three reviewed for resolution of grievances in the sample of seven. Findings Include: The Facility's undated Grievance/Concern Policy documents the purpose of the policy is to provide an opportunity for residents and/or family to present concerns or grievance to the proper authorities at the facility and to receive responses to the issues raised. The Grievance/Concern policy documents, It is the responsibility of the Department Directors to follow-up on the concerns and to ensure appropriate resolution. A copy of Concerns Forms must be sent to the Administrator for signature. Complaints may be presented to any staff member who should then report the issue to his/her supervisor and/or Social Services as soon as possible. Social Services will be responsible for completing the necessary documentation and to follow up with the resident and/or resident representative to assure a resolution. Social Services will maintain the Concern/Grievance Log. The Concern/Grievance forms and log will be kept for a minimum of 2 years. The Facility's Grievance Log had no grievances listed for May, June, July or August 2024. On 8/9/24 at 11:00 AM, V5 (R3's Health Care Power of Attorney) stated I had a lot of concerns regarding (R3), she wasn't getting a treatment done on her foot like she should, she kept getting regular liquids, and I had a lot of concerns regarding the CNAs (Certified Nursing Assistants) not having access to Electronic Medical Records. I spoke with (V1/Administrator) twice and she promised me both times that she was going to address my concerns, so I gave her time. She did nothing to address any of it. On 8/10/24 at 10:00 AM, V1 (Administrator) confirmed that V5 had come to her two times regarding concerns. V1 stated, She had a whole list of things she was not happy about. I think most of it was the wound on (R3's) foot, something about (R3)'s water, and that no one knew what they were doing. V1 confirmed that she had no documentation of any grievances put forth by V5. V1 could not state what she had done to address these concerns. I accept that I dropped the ball on that (addressing V5's concerns).

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 33970 Based on observation, interview, and record review, the facility failed to complete wound assessment documentation and perform wound care for (R4) and failed to provide thickened water in between meals for (R3 and R7) for three of three residents (R3, R4, and R7) reviewed for quality of care in the sample of seven. Findings Include: 1. The Facility's undated Skin Care Ulcers policy documents good skin care is important to maintain good health and prevent pressure areas. The integrity of skin should be maintained as the first line of defense against infections and pressure ulcers. Documentation will be done on all types of skin ulcers. Licensed staff and CNA will be responsible for providing nursing interventions for those residents with ulcers. Treatments for all ulcers will be ordered by the Physician. Licensed staff will be responsible for providing the treatment ordered by the physician. R4's current MDS (Minimum Data Set) Assessment documents R4's BIMS (Brief Interview for Mental Status) score as 15 out of 15, indicating R4 is cognitively intact. R4's Physician Order Sheet for July 2024 documents Silvadene External Cream 1% (percent), apply to right lower extremity at bedtime for redness/discoloration. R4's Treatment Administration Record does not contain documentation that this treatment was done on 7/5/24,7/15/24 or 7/16/24. R4's Medical Record does not contain any description, measurements, onset date, or what type of wound R4's wound on R4's right lower extremity is. R4's Physician Order Sheet for July 2024 documents Skin abrasion to right knee area. Cleanse with normal saline and apply calcium alginate and cover with border dressing, change daily until healed. R4's Treatment Administration Record does not contain documentation that this treatment was done on 7/4/24-7/7/24, 7/11/24, 7/12/24, 7/15/24,7/16/24,7/21/24 and 7/23/24-7/25/24. On 8/11/24 at 9:30 AM, R4 stated None of my treatments get done all of the time. It usually depends on who is working and if they are busy. I have asked multiple times for the cream to be left at my bedside because I could just do them myself. On 8/11/24 at 11:00AM, V2 (Director of Nursing) confirmed that there was no documentation regarding the description, size or source of R4's wounds in her medical record. V2 Also confirmed that there was no documentation of the listed days that R4's treatments were done. If it isn't signed off then I cannot prove that it was done. It should have been signed off by the nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The Facility's undated Thickening Liquids policy documents, Residents who have swallowing difficulties will be screened/evaluated by the speech therapist. A Physician order for thickened liquids will be obtained upon the recommendation of the speech therapist. The nursing staff will offer the resident thickened liquids between meals. R3's Physician Order Sheet dated July 2024 documents that R3 should receive Nectar thick- mildly thick liquids. On 8/9/24 at 11:00 AM, V5 (R3's Health Care Power of Attorney) stated, They (staff) kept giving (R3) regular unthickened liquids instead of thickened liquids like the doctor said to do. I came in on multiple occasions to find regular water at (R3's) bedside instead of thickened. I would dump the regular water out and ask for thickened water. On 8/9/24 at 1:00 PM, V7 (Certified Nurse Aide) confirmed that she had once been alerted by R3's family member that R3 had received regular water on the previous shift so V7 had to pour out the regular water and provide thickened water. On 8/11/24 at 11:00 AM, V1 (Administrator) confirmed that V5 (R3's Health Care Power of Attorney) had voiced complaints to V1 about R3 not getting thickened liquids as ordered two times since R3 was admitted . R3 was not present during this survey and was unable to be interviewed/observed. 3. R7's Physician Order Sheet dated July 2024 documents that R7 should receive Nectar thick-mildly thick liquids. On 8/10/24 at 9:30 AM on R7's bedside table there was a water pitcher with a straw in it. The pitcher contained unthickened water. On 8/10/24 at 9:35 AM, V11 (Registered Nurse) confirmed that R7's water pitcher was full of unthickened water and that R7 should not have been given regular water because R7 should have thickened liquids.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33970 Based on record review and interview, the facility failed to obtain physician orders for treatment of a pressure ulcer wound in a timely manner and failed to document weekly pressure ulcer wound assessments for one of three residents (R3) reviewed for wounds in the sample of seven. Findings Include: The Facility's undated Skin Care/Ulcers policy documents Good skin care is important in order to maintain good health and prevent pressure area. The integrity of the skin should be maintained as the first line of defense against infections and pressure ulcers. Documentation will be done on all types of skin ulcers. The unit coordinator will document when and where the ulcer developed, and interventions used in the nursing notes. The condition of the area including size, appearance, drainage, odor and progress will be documented on the weekly pressure ulcer healing assessment on a weekly basis using the following guidelines. 1. Be specific with the location of the wound. 2. Note the condition of the skin around the area 3. Note the size of the wound. Measure accurately. If unable to measure, compare the size to something else, i.e. nickel or quarter. 4. Note any drainage and odor 5. Note color 6. state the stage of the wound as defined. The Facility's Skin Care/Ulcer policy documents Licensed staff and CNA (Certified Nursing Assistants) will be responsible for providing nursing interventions for those residents with ulcers. Treatments for all ulcers will be ordered by the physician. On 8/9/24 at 11:00 AM, V5 (R3's Health Care Power of Attorney) stated, I told multiple staff members, including (V1/Administrator) and (V2/Director of Nursing) that (R3) had an open area on her heel, and no one did anything about it. R3's Skin Only Evaluation dated 7/23/24 at 7:06 PM documents New Issue Type: Pressure Ulcer/Injury. Location: Left Heel measuring 2 cm/centimeters by 2 cm and described as open. This same note does not contain documentation of physician notification or that treatment orders were received. R3's Nurse's notes do not include any further documentation regarding R3's left heel pressure ulcer. R3's Treatment Administration Record for July 2024 documents Calcium Alginate with Silver to left heel every day shift for wound care, Cleanse area with Normal Saline, Apply Calcium Alginate with Silver cover with (waterproof) dressing. The start date for this order was listed as 7/30/24. The Treatment Administration Record showed documentation of 5: Hold/See Nurse's Notes for 7/30/24 and 7/31/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/9/24 at 12:45 PM, V2 (Director of Nursing) confirmed R3's pressure ulcer to her left heel was discovered on 7/23/24 and she was not sure why there was no doctor notification or treatment ordered on 7/23/24. V2 also confirmed that the two days marked 5: Hold/See Nurse's Notes did not have any corroborating nurse's notes as to why the treatment wasn't completed. V2 stated, It shows that it was not done but does not say why. That nurse no longer works here, so I do not know why R3 went so long with no orders or why it wasn't done when we did have orders. V2 also confirmed no further wound measurements of R3's left heel pressure ulcer were obtained after 7/23/24.