

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265390	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2025
NAME OF PROVIDER OR SUPPLIER Sunset Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 400 West Park Avenue Union, MO 63084	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to keep Resident #2 from striking Resident #1 twice to the chest. The facility census was 114.</p> <p>The administrator was notified on 3/27/25 of past Non-Compliance, which occurred on 3/22/25 when Resident #1 struck Resident #2 to the chest twice. Staff immediately separated the residents, assessed the residents, notified the resident's physician, moved Resident #1 to a different hallway, put Resident #2 on one on one, and in-serviced nursing staff on abuse and neglect. Staff corrected the deficient practice on 3/25/25.</p> <p>1. Review of the facility's Abuse prevention policy, dated 10/21/22, showed abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, mental anguish, or emotional distress. This includes the deprivation by an individual, including a caretaker of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being. Abuse may be resident to resident, staff to resident, family to resident, or visitor to resident.</p> <p>Review of the facility's investigation, dated 3/23/25, showed Resident #1 wandered the hallway and came across the doorway of Resident #2. Resident #2 reached out and struck Resident #1 with a closed fist. Staff immediately separated the residents and while redirecting Resident #1 to the dining room, Resident #2 came around staff and struck Resident #1 again twice with a closed fist to the chest. Resident #2 was placed on one on one surveillance and Resident #1 was moved to a different locked unit with a longer hallway. All necessary parties were contacted, Labs were obtained on Resident #2 to rule out any chemical imbalances, Resident #2 had medication changes, care plans were updated, and all staff were in-serviced on abuse and neglect and the seven principles for effective verbal intervention.</p> <p>Review of Resident #1's Minimum Data Set (MDS), a federally mandated assessment tool, dated 3/7/25, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> -Moderate cognition impairment; -Short and long term memory problems; -Diagnoses of Alzheimer's and Dementia. <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's care plan, dated 3/24/25, showed staff assessed the resident with impaired cognitive function/dementia or impaired thought processes. Diagnosis of Alzheimer's. Staff were directed to move the resident from 300 hall to 200 hall. The resident is often noted to wander throughout the lockdown units, in and out of others rooms, redirect when this is noted to a common area or back to his room.</p> <p>Review of the nurses notes, dated 3/22/25 at 4:15 P.M., Licensed Practical Nurse (LPN) C documented Certified Medication Technician (CMT) A stated the resident had wandered into another resident's room, other resident got upset and hit resident in chest with closed fist. Director of Nursing (DON) notified of recent altercation. DON gave orders to moved resident to different hallway after altercation.</p> <p>Review of Resident #2's MDS, dated [DATE], showed staff assessed the resident as:</p> <ul style="list-style-type: none"> -Severe cognitive impairment; -Short term memory problems; -Diagnoses of Huntington's disease (condition in which nerve cells in the brain break down over time) and Psychotic disorder with delusions. <p>Review of the resident's care plan, dated 3/24/25, showed staff documented the resident has a history of aggression against other. Staff were directed to have the resident one on one with the social worker three times per week indefinitely, resident is to remain on 15 minute checks indefinitely due to aggression to other resident and accusations against staff, and attempt to keep resident in sight with two staff members on the unit at all times.</p> <p>Review of the residents nurses notes, dated 3/22/25 at 4:15 P.M., showed LPN C charted recent altercation with another resident. This nurse was called down to unit because resident was witnessed to hit another resident in the chest. Resident stated, I don't want him in my room. DON notified of recent altercation. Resident remains one on one and with 15 minute checks. Will continue to monitor during shift.</p> <p>During an interview on 3/27/25 at 10:40 A.M., CMT A said he/she didn't witness the altercation but was made aware by CNA B. He/She said CNA B and hospitality aide D immediately separated the residents and took Resident #1 to his room. He/She said at this time he/she went to tell the charge nurse what had happened. When he/she was telling the charge nurse what happened hospitality aide D stepped off the hall to inform them Resident #2 had struck Resident #1 again through CNA B and hospitality aide D. He/She said he/she and the charge nurse went back on the unit so the nurse could assess the residents and notify the DON. He/She said he/she was inserviced 3/22/25 over abuse and neglect and dealing with resident's with behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/27/25 at 10:50 A.M., CNA B said he/she was in the hallway when Resident #1 walked by Resident #2's door. Resident #2 reached out and hit Resident #1 with a closed fist. He/She said he/she and hospitality aide D immediately separated the residents and took Resident #1 to his/her room after he/she had notified the CMT. He/She said they took Resident #1 to his/her room so the nurse could assess him/her but he/she started to become agitated. He/She said he/she and hospitality aide D walked with Resident #1 toward the dining room. He/She said Resident #2 had stayed in his/her room but came out as they were going into the dining room. He/She said Resident #2 pushed him/her and again struck Resident #1. The CNA said he/she took Resident #1 back to his/her room for the nurse to assess and hospitality aide D went to notify the nurse of the second strike. He/She said he/she was inserviced on 3/22/25 over abuse and neglect and resident behaviors.</p> <p>During an interview on 3/27/25 at 11:03 A.M., LPN C said CMT A came to him/her and reported Resident #2 had stuck Resident #1. The LPN said they went to the unit and it was reported by hospitality aide D, Resident #2 had struck Resident #1 again between him/her and CNA B. He/She contacted the DON who instructed staff to move Resident #1 to 200 hall and put Resident #2 one on one. He/She said he/she assessed Resident #1 and Resident #2 refused his/her assessment. He/She said he/she was inserviced on 3/22/25 on abuse and neglect and deescalating resident to resident altercations.</p> <p>During an interview on 3/27/25 at 11:22 A.M., CNA E said Resident #2 had struck Resident #1 twice. He/She said Resident #2 was put one on one and Resident #1 was moved to a different hallway. He/She said he/she was inserviced on 3/22/25 on abuse and neglect and what to do when residents become combative.</p> <p>During an interview on 3/27/25 at 11:52 A.M., the DON said he/she was made aware of the altercations by LPN C. He/She instructed staff to stay one on one with Resident #2 and to move Resident #1 to 200 hallway. He/She said inservice over abuse and neglect and the seven principles for effective verbal intervention starting on 3/22/25 and finished on 3/25/25.</p> <p>During an interview on 3/27/25 at 12:03 P.M., the administrator said he/she was notified by the DON about the altercation between Resident #1 and Resident #2. He/She said an investigation was started and the resident's were separated, Resident #1 was moved to a new hallway and Resident #2 was put one on one with staff. He/She said the DON called all necessary parties and received orders for medication changes for Resident #2. He/She said all staff were inserviced on abuse and neglect and the seven principles for effective verbal intervention.</p> <p>MO00251529</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to provide an appropriate emergency discharge notice when staff failed to have an appropriate location to transfer one resident (Resident #2) to when he/she was ready to discharge from the hospital. The facility census was 114.</p> <p>1. Review of the facility's Discharge and Transfer - Involuntary Policy, reviewed 10/07/2021, showed transfer and discharge includes movement of a resident to a bed outside of the facility whether that bed is in the same physical plant to not. The facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless specific criteria are met. The facility will provide sufficient orientation to residents to ensure a safe and orderly transfer or discharge from the facility including an opportunity to participate in the decision of where to transfer.</p> <p>2. Review of Resident #1's facesheet, dated 4/3/25, showed the resident admitted to the facility on [DATE].</p> <p>Review of the residents progress notes, dated 3/27/2025, at 4:42 P.M., showed staff documented they spoke with the residents guardian in regard to a notice of immediate discharge of the resident related to aggressive behavior toward another resident.</p> <p>Review of the resident's Immediate Discharge Notice, dated 3/27/25, showed staff documented the resident would discharge to the local hospital.</p> <p>During an interview on 4/3/25 at 10:03 A.M., the administrator said the resident is too aggressive to continue to be at the facility and he/she knows it is an issue with the placement of discharge at the hospital but he/she has to keep the other residents in the facility safe and can not allow the resident to return.</p> <p>During an interview on 4/3/25 at 10:13 A.M., the residents guardian said the facility has issued an emergency discharge to the local hospital and that is not a long term safe placement for the resident. The guardian said he/she has started the appeals process but the facility will not allow the resident to return and because of his/her extreme diagnoses no one will take the resident.</p> <p>MO00251810</p>		