

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	

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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident when there is a significant change in condition</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and review of the Resident Assessment Instrument (RAI) manual, the facility failed to complete a significant change assessment after a resident was started on hospice services for one of two residents (Resident (R) 7) reviewed for hospice of 16 sample residents. This has the potential to affect all residents with a Minimum Data Set (MDS) assessment ensuring proper care and services. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the undated Minimum Data Set Resident Assessment Instrument (RAI) revealed Guidelines for determining the need for an SCSA [significant change in status assessment] for residents with terminal conditions. The key in determining if an SCSA is required for individuals with a terminal condition is whether or not the change in condition is an expected well-defined part of the disease course and is consequently being addressed as part of the overall plan of care for the individual. If a terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration, an SCSA assessment is required. Similarly, if the resident enrolls in a hospice (Medicare Hospice program or other structured hospice program), but remains a resident at the facility, an SCSA should be performed if the terminally ill resident experiences a new onset of symptoms or a condition that is not part of the expected course of deterioration. The facility is responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.</p> <p>Review of R7's Admission Record located in the Profile tab of the electronic medical record (EMR), revealed re-admission to the facility on [DATE] and with diagnosis of mild intermittent asthma.</p> <p>Review of R7's quarterly MDS under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 04/08/24, revealed the Brief Interview for Mental Status (BIMS) could not be completed due to resident rarely being understood.</p> <p>Review of R7's Physician Orders located under the Orders tab of the EMR, dated 07/09/24, revealed an order for hospice.</p> <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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	

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 0637</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/25/24 at 11:16 AM, the MDS coordinator (MDSC) stated she was new to the position and has only been doing this for two weeks. She stated a significant change assessment needed to be completed anytime someone went on hospice. She stated she found out on the 11th during a care plan meeting that R7 went onto hospice, and there was a quarterly assessment open, so she was confused if a significant change assessment needed to be completed.</p> <p>During an interview on 07/25/24 at 12:59 PM, the Director of Nursing (DON) stated R7's wife spoke with the provider directly and requested the resident be placed on hospice. She agreed the facility became aware on the 11th and that a significant change assessment should have been completed.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review and interview, the facility failed to develop and implement a care plan for a resident receiving hospice services for one of two residents (Resident (R) 7) reviewed for hospice services of 16 sample residents. This has the potential to affect all residents receiving hospice services. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Care Plans, Comprehensive Person Centered, revised March 2023, revealed the comprehensive, person-centered care plan was developed within seven days of the required MDS [Minimum Data Set] assessment.</p> <p>Review of R7's Admission Record located in the Profile tab of the electronic medical record (EMR), revealed re-admission to the facility on [DATE] and with diagnosis of mild intermittent asthma.</p> <p>Review of R7's quarterly MDS under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 04/08/24, revealed the Brief Interview for Mental Status (BIMS) could not be completed due to resident rarely being understood.</p> <p>Review of R7's care plan located under the "Care Plan" tab of the EMR and dated 04/10/24, revealed the resident was not care planned for hospice services.</p> <p>Review of R7's Physician Orders located under the Orders tab of the EMR, dated 07/09/24, revealed an order for hospice.</p> <p>During an interview on 07/25/24 at 11:16 AM the MDS coordinator (MDSC) stated she was new to the position and there were two residents who went on hospice. She stated she must have care planned the other resident and forgot to implement R7's care plan for hospice, but it should have been done. She stated it was important to care plan it so that staff were aware he was hospice and did not require any medical treatment if he got sick.</p> <p>During an interview on 07/25/24 at 12:59 PM, the Director of Nursing (DON) stated R7's wife spoke with the provider directly and requested the resident be placed on hospice. But agreed the facility became aware on the 11th and that hospice should have been implemented on the care plan.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693</p> <p>Based on observation, record review, and staff interview, the facility failed to ensure resident were appropriately assessed and had documentation to support the use of wander guards for two of two residents (Residents (R) 34 and R12) reviewed for wander guards of 16 sample residents. This failure could result in residents with unwarranted use of wander guards.</p> <p>Findings include:</p> <p>During an interview on 07/25/24 at 2:45 PM, the Director of Nursing (DON) stated the facility did not have a policy related to wander guard use.</p> <p>1. Review of R34's Resident Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R34 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, unspecified severity, without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of R34's quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 06/09/24 revealed R34 had short-term and long-term memory problems with cognitive skills for daily decision making rated as severely impaired. Further review of the MDS revealed R34 had not exhibited physical, verbal, or other behavioral symptoms not directed toward others and had not exhibited wandering. The resident was marked as having a wander guard.</p> <p>Review of R34's Care Plan located under the Care Plan tab of the EMR, last revised 06/21/24, revealed a problem category Cognitive Loss/Dementia related to wandering and risk for elopement. Interventions included to equip the resident with a device that alarms when resident wanders and to check for proper functioning of device every shift.</p> <p>Review of R34's Active Orders located under the Orders tab in the EMR, dated 02/08/24, revealed an open-ended order for Wander Guard Special Instructions: Place wander guard on res [resident] d/t [due to] elopement risk.</p> <p>Review of R34's Observations located under the Observations tab in the EMR, from 12/09/22 to 07/24/24, revealed no assessments for elopement risk.</p> <p>Review of R34's Progress Notes located under the Progress Notes tab in the EMR, from 08/22/23 to 07/24/24, revealed no assessments for elopement risk or notes indicating R34 exhibited wandering or elopement behaviors.</p> <p>During an observation on 07/24/24 at 10:37 AM, R34 was observed quietly sitting in a recliner in his room and eating a breakfast bar. R34 smiled pleasantly and appeared in no acute distress.</p> <p>During an observation on 07/24/24 at 11:50 AM, R34 was observed ambulating down the hall to the main dining room, assisted by a male staff member. R34 appeared calm and compliant with going to the dining room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 07/24/24 at 1:00 PM, R34 was observed ambulating down the hall from the main dining room back toward his room, assisted by a female staff member. R34 appeared calm and compliant with following staff direction/redirection.</p> <p>During an interview on 07/24/24 at 11:58 AM, the Infection Preventionist (IP) stated the elopement evaluations were located under the Observations tab in the EMR. She stated that was the only place so if there were no elopement evaluations there then there was not one done.</p> <p>During an interview on 07/23/24 at 2:00 PM the MDS Coordinator (MDSC) stated R34 previously lived at the assisted living and had wandered across the street in the middle of the night. It was decided R34 needed to be moved to the nursing facility and the wander guard was placed. The MDS nurse stated R34 had the wander guard in place since admission because of that incident.</p> <p>During an interview on 07/23/24 at 2:30 PM, Licensed Practical Nurse (LPN) 2 stated R34 did not exit seek.</p> <p>During an interview on 07/23/24 at 2:33 PM, Certified Medication Technician (CMT) 3 stated R34 did not exit seek or leave his room.</p> <p>During an interview on 07/23/24 at 2:38 PM, Certified Nurse Aide (CNA) 1 stated R34 did not wander, or exit seek.</p> <p>2. Review of R12's Resident Face Sheet located in the Face Sheet tab of the EMR revealed R12 was admitted to the facility on [DATE] with diagnoses which included dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of R12's quarterly MDS located in the MDS tab of the EMR, with an ARD of 06/18/24 revealed R12 had a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident had severe cognitive impairment. Further review revealed no physical, verbal, or other behavioral symptoms not directed toward others and no presence of wandering. The was marked as having a wander guard.</p> <p>Review of R12's Care Plan located under the Care Plan tab of the EMR, last revised 07/07/24 revealed a problem category Behavioral Symptoms related to R12 wandering and attempting to go outside unsupervised in the past. Interventions included to equip the resident with a device that alarms when resident wanders and to check for proper functioning of device every shift.</p> <p>Review of R12's Active Orders located under the Orders tab in the EMR, dated 03/11/24, revealed an open-ended order for Wander Guard Check Special Instructions: Ensure wander guard is in place, skin is intact surrounding wander guard, check function of wander guard with tool provided in treatment cart.</p> <p>Review of R12's Observations located under the Observations tab in the EMR, from 11/30/22 to 07/24/24, revealed no assessments for elopement risk.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R12's Progress Notes located under the Progress Notes tab in the EMR, from 03/01/24 to 07/24/24, revealed no assessments for elopement risk. Review revealed a note dated 03/08/24, indicating R12 attempted to leave the facility by following a visitor out the front door and stated, get me out of here.</p> <p>During an observation on 07/24/24 at 10:10 AM, R12 was observed sitting quietly in her room in no apparent distress.</p> <p>During an observation on 07/24/24 at 11:50 AM, staff were observed assisting R12 to the dining room in her wheelchair. R12 appeared calm and in good spirits.</p> <p>During observation on 07/24/24 at 3:37 PM, R12 was observed sitting calmly in her wheelchair in front of the nurse's station.</p> <p>During an interview on 07/25/24 at 3:30 PM, LPN 1 stated R12 did not exit seek or wander any longer since R12 has been in a wheelchair.</p> <p>During an interview on 07/25/24 at 3:36 PM, CNA2 stated the resident did not exit seek or wander any longer since R12 has been in a wheelchair.</p> <p>During an interview on 07/25/24 at 3:45 PM, CMT2 indicated resident did not exit seek or wander any longer since R12 has been in a wheelchair. She estimated R12 has been in a wheelchair a little over a month ago. The facility census was 46.</p> <p>During an interview on 07/25/24 at 11:47 AM, the Rehabilitation Director stated the rehabilitation staff did not conduct evaluations for wander guard use.</p> <p>During an interview on 07/24/24 at 1:05 PM, the DON stated the facility did not have a formal evaluation for elopement risk or wander guard use. She stated for R34 specifically, the wander guard was placed because R34 had eloped when R34 resided at the assisted living. The DON stated the facility received an Immediate Jeopardy (IJ) for the elopement and it was decided R34 would be safer in long term care with the wander guard. The DON stated the residents with wander guards have them because they either had an elopement, near elopement, or were exit seeking. When asked again about a formal evaluation for elopement she stated they only looked at behaviors. When asked if R34 had behavior monitoring, she stated R34 did not have behavior monitoring because R34 did not exhibit behaviors. The DON stated the wander guard order for R34 was renewed on 02/08/24 because the facility had received an IJ for the elopement before R34 admitted to long term care, and they felt it was best R34 remain with the wander guard.</p> <p>During an interview on 07/25/24 at 5:22 PM, the Administrator stated the facility placed the wander guard on R34 because the facility received an IJ for the elopement incident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622</p> <p>Based on observation, interview, record review, facility policy review, and review of manufacturer's instructions, the facility failed to provide respiratory care in accordance with professional standards for two of two residents (Residents (R) 3 and R99) reviewed for respiratory care out of 16 sample residents. This failure has the potential for the residents to be subjected to contaminated respiratory equipment and to not receive proper airflow. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Departmental (Respiratory Therapy) - Prevention of Infection, dated 11/11, documented: .8. Keep oxygen cannula and tubing used as needed (PRN) in a plastic bag when not in use. 9. Wash filters from oxygen concentrators every seven (7) days with soap and water. Rinse and squeeze dry.</p> <p>Review of the undated Maintenance instruction sheet, provided by the facility, revealed remove the filter and clean at least once a week depending on environmental conditions.</p> <p>1. Review of R3's Admission Record located under the Resident tab of the electronic medical record (EMR), revealed R3 was admitted on [DATE] with diagnoses of unspecified dementia, nasal congestion, and atherosclerotic heart disease of native coronary artery without angina pectoris.</p> <p>Review of R3's significant change Minimum Data Set (MDS), dated [DATE] and located in the EMR under the MDS tab, revealed R3 had a Brief Interview for Mental Status (BIMS) score of zero out of 15, which indicated R3 had severe cognitive impairment.</p> <p>Review of R3's Physician Orders Sheet, located in the EMR under the Orders tab, revealed the following order, dated 07/03/24, oxygen - apply per nasal cannula PRN if oxygen saturation (O2) sats less than 90 %. May titrate as needed.</p> <p>Review of R3's Care Plan, dated 04/24/24 and located in the EMR under the Care Plan tab, revealed the following: At risk for decreased cardiac output related to (R/T) chronic diastolic congestive heart failure (CHF). Interventions included the following, monitor O2 saturation as needed. The care plan and interventions did not include the use of oxygen for R3.</p> <p>During an observation on 07/22/24 at 10:27 AM, the nasal cannula was on the floor beside the resident's bed.</p> <p>During an observation on 07/22/24 at 11:05 AM, the oxygen tubing and cannula were on the floor beside the resident's bed.</p> <p>During an observation on 07/23/24 at 8:18 AM, the date on the tubing indicated it was changed on 07/16/24. The resident was using oxygen at this time.</p> <p>During an interview on 07/23/24 at 12:25 PM, Registered Nurse (RN) 1 verified R3's nasal cannula and tubing and stated it should not have been on the floor.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/23/24 at 12:27 PM, the Director of Nursing (DON) stated oxygen tubing and cannulas should not have been on the floor. The DON stated they should have been stored in a plastic bag when not in use.</p> <p>2. Review of R99's Admission Record, located under the Resident tab of the EMR, revealed R99 was admitted [DATE] with diagnoses of acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure and hypertension.</p> <p>Review of R99's admission MDS located in the EMR under the MDS tab, dated 06/24/24, revealed the resident had a BIMS of 11 out of 15, indicating R99 had moderately impaired cognition.</p> <p>Review of R99's Physician Orders Sheet, located in the EMR under the Orders tab, revealed the following order, dated 06/19/24: apply oxygen 1-5 liters as needed.</p> <p>Review of R99's Care Plan located in the EMR under the Care Plan tab, dated 06/21/24, did not address R99 being on oxygen therapy.</p> <p>During an observation on 07/22/24 at 9:55 AM, R99 had a dirty oxygen filter covered with white dust, and the oxygen tubing and cannula were on the floor.</p> <p>During an observation on 07/22/24 at 12:35 PM, the oxygen tubing was still on the floor, and the oxygen filter was still covered with thick white dust.</p> <p>During an observation on 07/23/24 at 8:11 AM, the oxygen filter was still covered with a thick white dust.</p> <p>During an observation on 07/23/24 at 12:07 PM, the oxygen tubing and cannula were on the floor and the filter still was covered with a build-up of white dust.</p> <p>During an interview on 07/23/24 at 12:22 PM, RN1 verified R99's oxygen concentrator tubing was on the floor and, the oxygen filter was covered with white dust. RN1 stated she thought the filters were supposed to be cleaned weekly when the oxygen tubing was changed.</p> <p>During an interview on 07/23/24 at 12:27 PM, the DON stated the oxygen concentrator filters should have been cleaned monthly on the night shift.</p> <p>During an interview on 07/23/24 at 1:05 PM, the DON verified the filters should have been cleaned weekly during the tubing change. The DON provided manufacturer guidelines for cleaning and maintenance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40902</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails for one of two residents (Resident (R) 22 and R37) reviewed for side rails of 16 sample residents. The lack of alternative side rail measures could lead to potential restraint or side rail entrapment. The facility census was 46.</p> <p>Findings include:</p> <p>1. Review of R22's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed re-admission to the facility on [DATE] with a diagnosis of muscle weakness.</p> <p>Review of R22's annual Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 04/21/24 revealed a Brief Interview for Mental Status (BIMS) score could not be completed due to the resident rarely understood.</p> <p>Review of R22's care plan located under the "Care Plan" tab of the EMR and dated 07/08/22, revealed "The resident had 1/2 side rails on bed for bed mobility.</p> <p>Review of R22's Physician Orders located under the Orders tab of the EMR, dated 06/29/23, revealed an order for side rails.</p> <p>Review of R22's Side Rail Assessment located under the Observations tab of the EMR, dated 06/16/24, revealed no documentation of alternative measures. Further review revealed only risk and benefits and consent were obtained.</p> <p>2. Review of R37's Admission Record located in the Profile tab of the EMR revealed re-admission to the facility on [DATE] with a diagnosis of chronic kidney disease.</p> <p>Review of R37's quarterly MDS under the MDS tab of the EMR with an ARD of 05/03/24 revealed the BIMS indicated a score of two of 15 which indicated severe cognitive impairment.</p> <p>Review of R37's care plan located under the "Care Plan" tab of the EMR and dated 02/02/23, revealed "The resident had 1/2 side rails on bed for bed mobility. Further review revealed the resident requested the use of side rails as a fall prevention.</p> <p>Review of R37's Physician Orders located under the Orders tab of the EMR, dated 02/01/23, revealed an order for side rails.</p> <p>Review of R37's Side rail Assessment located under the Observations tab of the EMR, dated 05/01/24, revealed no documentation of alternative measures. Further review revealed only risk and benefits and consent were obtained.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 07/25/24 at 11:16 AM, the MDS coordinator (MDSC) stated if they identified that a resident would benefit from side rails they would have therapy evaluate the resident and if they decided to go forward they would get a physician order. She stated they would have a side rail assessment completed. But she said she was not aware that staff had to look at alternatives and document those attempts prior to using bedrails for a resident. She stated they were assessing for entrapment, and they had documentation for that.</p> <p>During an interview on 07/24/24 at 5:00 PM, the Administrator stated she was unaware that alternatives had to be attempted prior to installing bedrails and asked what type of alternates could be tried.</p> <p>During an interview on 07/25/24 at 12:59 PM, the Director of Nursing (DON) stated she was unaware staff needed to explore alternatives. She stated she knew to use the least restrictive but did not know about the alternatives. She stated she did not know what to do when a family or resident requested or insisted on having bedrails.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure residents received the correct medication as ordered by the physician for two of eight residents (Resident (R) 20 and R38) reviewed for medications of 16 sample residents. This failure could result in unwarranted medication side effects and mismanaged medical conditions. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Administering Medications, revised April 2019, revealed Medications are administered in a safe and timely manner, and as prescribed.</p> <p>1. Review of R20's Resident Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R20 was admitted to the facility on [DATE] with diagnoses which included chronic diastolic (congestive) heart failure and essential (primary) hypertension.</p> <p>Review of R20's quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 05/28/24, revealed R20 had a Brief Interview for Mental Status (BIMS) score of six out of 15 which indicated the resident had severe cognitive impairment.</p> <p>Review of R20's Care Plan located under the Care Plan tab of the EMR, last revised 06/19/24, revealed a problem category ADLs [activities of daily living] Functional Status/Rehabilitation Potential related to a diagnosis of hypertension. However, this problem category did not include any specific intervention related to medication administration.</p> <p>Review of an Event Report, dated 03/22/24 and provided by the facility, revealed a hospital discharge order for R20 for metoprolol succinate [blood pressure medication] 25 mg [milligrams] 24 hr [hour] tablet, Take 3 tablets (75 mg total) by mouth daily.</p> <p>Review of the Event Report indicated an order for metoprolol tartrate 25 mg (75 mg) Administer 3 tablets twice daily was entered in error. The Type of Error was checked off as Incorrect Dose, Incorrect Medication, and Incorrect Time.</p> <p>Review of R20's Order located under the Orders tab in the EMR, revealed an order with a start date of 03/19/24 and a discontinue date of 03/22/24 for metoprolol tartrate 75 mg twice a day.</p> <p>Review of R20's Medication Administration Record (MAR), dated 03/24 and located under the Reports tab in the EMR, revealed R20 received four days of metoprolol tartrate 75 mg twice daily.</p> <p>During an interview on 07/25/24 at 1:21 PM the Director of Nursing (DON) stated she entered the metoprolol succinate order incorrectly and, as a result, R20 received at least three days of twice daily dosing of metoprolol tartrate instead of once daily of the tartrate.</p> <p>2. Review of R38's Admission Record, located in the Profile tab of the EMR revealed re-admission to the facility on [DATE] with a diagnosis of muscle Parkinson's.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R38's quarterly MDS under the MDS tab of the EMR, with an ARD of 06/12/24, revealed the BIMS score of 13 out of 15 which indicated the resident had intact cognition.</p> <p>Review of R38's care plan located under the "Care Plan" tab of the EMR and dated 02/04/23, revealed "The resident had a diagnosis of Parkinson's disease.</p> <p>Review of R38's Progress Note located under the Progress Notes tab of the EMR, dated 05/17/24, written by Registered Nurse (RN) 2, revealed received order to decrease from two tablets to 1.5 tablets QID [four times a day] for carbidopa-levodopa.</p> <p>Review of R38's Physician Order Clarification located under the Documents tab of the EMR, dated 06/11/24, revealed on 05/17/24 that resident's carbidopa-levodopa was decreased from 2 tablets to 1.5 QID but the order was entered wrong and has only been given TID.</p> <p>Review of R38's Medication Administration Record (MAR) located under the Reports tab of the EMR, dated 05/16/24 through 06/17/24, revealed R38 received 1.5 tablets of carbidopa-levodopa three times daily between 05/17/24-06/12/24.</p> <p>During an interview on 07/25/24 at 10:23 AM, RN2 stated when staff received a verbal order, they wrote the order down in their fax orders binder, faxed it to the pharmacy, made a progress note, entered the order in computer and notified the family. RN2 stated she could not recall the progress note she wrote on 05/17/24, but she did remember something about the ear but nothing else. She stated she must have just missed that one piece of the order and did not enter it correctly, but she was not sure what happened.</p> <p>During an interview on 07/25/24 at 12:59 PM, the Director of Nursing (DON) stated they identified an issue with nursing staff taking phone orders which has led to these types of situations where orders were not put into the EMR accurately. She stated their process was a two-step process that required two nurses to sign off for accuracy. The DON stated staff were just taking the orders verbally and putting them directly into the EMR which omitted the 2nd check. She stated she expected staff to input orders accurately and follow them.</p> <p>40902</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35693</p> <p>Based on record review, interview, and facility policy review, the facility failed to ensure there was documented rationale and a stop date for a PRN (as needed) psychotropic medication for one of eight residents (Resident (R) 12) reviewed for medications of 16 sample residents. This failure has the potential to lead to unwarranted medication side effects. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Psychotropic Medication Use, dated July 2022, revealed PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order.</p> <p>Review of R12's Resident Face Sheet located in the Face Sheet tab of the electronic medical record (EMR) revealed R12 was admitted to the facility on [DATE] with diagnoses which included dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety.</p> <p>Review of R12's quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 06/18/24, revealed R12 had a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident had severe cognitive impairment. Further review revealed no physical, verbal or other behavioral symptoms directed toward others.</p> <p>Review of R12's Care Plan located under the Care Plan tab of the EMR, last revised 07/07/24, revealed a problem category Psychotropic Drug Use related to antianxiety medication with interventions which included Attempt a gradual dose reduction as needed and ordered by PCP [primary care physician] .monitor for drug use effectiveness and adverse consequences, and pharmacy consultant review as needed and appropriate.</p> <p>Review of R12's Orders located under the Orders tab in the EMR, revealed an order for lorazepam (anti-anxiety medication) tablet 0.5 mg (milligrams) give one tablet by mouth twice daily as needed for anxiety. The order indicated it was started on 03/11/24 and discontinued on 06/07/24.</p> <p>Review of R12's March 2024, April 2024, May 2024, and June 2024 Medication Administration Record (MAR) revealed the lorazepam 0.5 mg give one tablet by mouth twice daily as needed for anxiety order remained active from 03/11/24 to the discontinuation date of 06/07/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R12's Progress Notes located under the Progress Notes tab in the EMR, revealed three notes by the clinical pharmacist referencing the pharmacy consultation requesting a review and resolution to the lorazepam order, specifically requesting to discontinue or continue the order with justification and a duration of use. The first note was dated 03/24/24, the second follow up note was dated 04/25/24, and the third follow up note was dated 05/21/24.</p> <p>Review of R12's pharmacy consultations revealed a note titled Note to Attending Physician/Prescriber, dated 3/26/24, notifying the prescriber of the lorazepam PRN order and the 14-day limit, with a request to either discontinue the order or extend the order with clinical rationale for a specified duration of use. The prescriber responded on 04/02/24 to continue the lorazepam PRN order but did not provide a rationale or duration of use.</p> <p>During an interview on 07/25/24 at 1:08 PM the Director of Nursing (DON) stated she recalled the issue with R12's lorazepam order. She stated the prescriber insisted on continuing the order. The staff was using the medication to help with giving R12 showers due to R12 becoming combative. The DON stated she asked if the physician would consider changing the order to give 30 minutes before showers, but it was denied. The DON stated during the three months where the PRN order was still in place; the facility was going back and forth with the prescriber trying to have the prescriber document justification and provide a stop date for the order.</p> <p>During an interview on 07/25/24 at 2:07 PM, the consulting Pharmacist stated she had conducted a review for R12 in March and again in May addressing the PRN lorazepam order. She stated the prescriber had not provided a rationale or end date to continue the PRN order.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622</p> <p>Based on interviews, record review, and review of facility policy, the facility failed to ensure one of one resident (Resident (R) 99) was free from significant medication errors when the facility administered R99 someone else's medication, out of 16 sample residents. This medication error had the potential to cause R99 to become hypotensive (low blood pressure). The facility census was 46.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Administering Medications, dated 04/19, revealed Medications are administered in a safe and timely manner, and as prescribed .9. The individual administering medications verifies the resident's identity before giving the resident his/her medications. Methods of identifying the resident include: (a) checking identification band; (b) checking photograph attached to medical record; and (c) if necessary, verifying resident identification with other facility personnel.</p> <p>Review of a professional reference titled Hypotension, dated 02/19/23 and retrieved from www.ncbi.nlm.nih.gov, revealed hypotension is classified based on the biometric parameters of the blood pressure measurement. It may be absolute with changes in systolic blood pressure to less than 90 millimeters of mercury (mm Hg) or mean arterial pressure less than 65 mm Hg. It may be relative to a decrease in diastolic blood pressure to less than 40 mm Hg.</p> <p>Review of R99's Face Sheet located under the Resident tab of the electronic medical record (EMR), revealed admission to the facility on [DATE] with diagnoses including anxiety disorder, unspecified, acute on chronic combined systolic and diastolic congestive heart failure, and chronic kidney disease, stage three.</p> <p>Review of R99's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/24/24 located under the Resident tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 indicating moderately impaired cognition.</p> <p>Review of the facility's Event Report located in the EMR under the Resident tab, dated 06/24/24 and time stamped at 8:40 AM, revealed R99 received Amlodipine 5 mg (medication used to treat high blood pressure), Atorvastatin 20 mg (medication used to treat high cholesterol), Hydralazine 50 mg (medication used to treat high blood pressure), Lisinopril 20 mg (medication used to treat high blood pressure and heart failure), Metoprolol 200 mg (a medication used to treat high blood pressure), Omeprazole 20 mg (medication used to treat gastroesophageal reflux disease), and Vitamin D3 125 mcg (supplement used to help the body absorb calcium and phosphorus). R99's blood pressure at 7:59 AM was 110/58. The event report revealed R99 was given another resident's medications during AM med pass.</p> <p>Review of R99's Orders located under the Resident tab of the EMR, revealed a physician order, dated 06/24/24, for lisinopril tablet 2.5 mg; 1 tab, hold if systolic blood pressure (SBP) less than 90 once a day, and metoprolol tartrate tablet; 100 mg, 1 tab, hold if SBP less than 90 and heart rate (HR) less than 50.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R99's vital signs report located under the Resident tab of the EMR, revealed the following blood pressure readings:</p> <p>06/24/2024 at 12:31 AM 120/90</p> <p>06/24/2024 at 7:35 AM 114/75</p> <p>06/24/2024 at 7:59 AM 110/58</p> <p>Review of R99's blood pressure (BP) readings for 06/24/24, between 7:35 AM and 7:59 AM, revealed the systolic blood pressure dropped 15 mm of Hg and the diastolic blood pressure dropped 20 mm of Hg.</p> <p>Review of R99's After Visit Summary (AVS) from [Name] Health System, dated 06/25/24, revealed R99 presented to [hospital name] ED [emergency department] on 06/24 with complaint of accidental medication ingestion. She resides at [Name] nursing home and was incorrectly given someone else's medications. She was given metoprolol 200 mg, lisinopril 20 mg, hydralazine 50 mg, and amlodipine 5 mg. She usually takes only metoprolol 100 mg and lisinopril 2.5 mg. In the ED she received a 500 ml fluid bolus. Work up in the ED revealed .BP 94/43. She was admitted to observation for further evaluation and treatment of hypotension secondary to medication. BP meds were held, and her hypotension resolved without further intervention.</p> <p>During an interview on 07/23/24 at 3:03 PM, the Director of Nursing (DON) stated R99 received R13's morning medications. She stated the medications were administered by a student nurse in the dining room. She stated R99 and R13 sat at the same table in the dining room, and the student nurse got the residents confused. The DON stated the Certified Medication Tech preceptor (CMT) 1 went over the medications with the student nurse and told her which resident needed the medications. The DON stated she was out of the building the day of the incident. The DON stated R99 became symptomatic quickly and was assessed by Registered Nurse (RN) 1.</p> <p>During an interview on 07/24/24 at 8:30 AM, RN1 stated she was notified within ten minutes of the incident regarding R99 receiving the wrong medications. RN1 stated she immediately assessed R99 and notified the physician. RN1 stated she checked R99's blood pressure again while waiting for a return call from the physician. RN1 stated R99's blood pressure was trending down, and she called the physician again. She stated new orders were received to send R99 to the hospital. She stated R99 was kept overnight for observation and received IV (intravenous) fluids. RN1 stated she also notified R99's son and the hospice agency.</p> <p>During an interview on 07/24/24 at 12:00 PM, the DON stated CMT1 was verbally counseled on the situation regarding the medication error.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30622</p> <p>40902</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure nursing staff properly stored nebulizer masks when not in use for two of two residents (Resident (R) 35 and R7) reviewed for nebulizers and ensure proper wound care procedures for one of one resident (R99) reviewed for wound care of 16 sample residents. This failure had the potential to contribute to the potential of contamination and spread of infection. The facility census was 46.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Wound Care, dated 10/10, under the Steps in Procedure section revealed, 1. Use disposable cloth (paper towel is adequate) to establish clean field on the resident's overbed table. Place all items to be used during the procedure on the clean field. Arrange the supplies so they can be easily reached .3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites.</p> <p>1. Review of R35's Admission Record located in the Profile tab of the electronic medical record (EMR) revealed admission to the facility on [DATE] and with diagnosis of paroxysmal atrial fibrillation.</p> <p>Review of R35's quarterly Minimum Data Set (MDS) under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 06/22/24 revealed the Brief Interview for Mental Status (BIMS) score of one out of 15 which indicated severe cognitive impairment.</p> <p>During observations on 07/23/24 at 12:30 PM and on 07/24/24 at 12:05 PM, the resident's nebulizer machine and mask were lying on top of paper towels by the sink in the resident's room, uncovered.</p> <p>2. Review of R7's Admission Record located in the Profile tab of the EMR revealed admission to the facility on [DATE] and with diagnosis of mild intermittent asthma.</p> <p>Review of R7's quarterly MDS under the MDS tab of the EMR with an ARD of 04/08/24 revealed the BIMS could not be completed due to resident rarely being understood.</p> <p>During observations on 07/23/24 at 12:30 PM and on 07/24/24 at 12:05 PM, the resident's nebulizer machine and mask were lying on top of paper towels by the sink and top of dresser by the resident's bed uncovered.</p> <p>During an interview on 07/24/24 at 12:08 PM, Registered Nurse (RN) 1 verified that both residents nebulizer masks were uncovered and not stored properly. RN1 stated nebulizer masks should not be left and they should be covered in a plastic bag. She stated the Certified Medication Technician (CMT) administered the nebulizer treatments, and they were responsible for storing them properly between use.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/24/24 at 3:55 PM, CMT4 stated after she finished administering a nebulizer treatment to a resident she was supposed to wash it, place it on a towel to dry, and place another paper towel over while it was drying. She stated she only tried to leave it to dry for about 15 minutes, but sometimes she forgot to go back. She stated she was just informed today that they should be storing the masks inside a plastic bag and that she did not know that before.</p> <p>During an interview on 07/25/24 at 12:59 PM, the Director of Nursing (DON) stated the nebulizer masks were supposed to be stored in clear plastic bags to keep them from getting dirt or debris on the mask and contain anything the resident had left on the mask.</p> <p>3. Review of R99's Face Sheet, located under the Resident Tab of the EMR revealed admission to the facility on [DATE] with diagnoses including anxiety disorder, unspecified, acute on chronic combined systolic and diastolic congestive heart failure, and chronic kidney disease, stage three.</p> <p>Review of R99's admission MDS with an ARD of 06/24/24 located under the MDS tab in the EMR revealed a BIMS of 11 out of 15 indicating moderate cognitive impairment.</p> <p>Review of R99's Orders located under the Resident tab of the EMR revealed a physician order, dated 07/02/24, cleanse upper right coccyx wound with normal saline (NS) wound cleanser, apply Xeroform gauze, cover with four-by-four Mepilex and sacral Mepilex once a day.</p> <p>Review of R99's Orders located under the Resident tab in the EMR revealed a physician order, dated 07/03/24, cleanse skin tear to inner areas of right lower extremity (RLE) et left lower extremity (LLE) inner calf with NS wound cleanser, pat dry, cover with Xeroform gauze, cover with supper absorbent dressing, secure with gauze wrap and Coban.</p> <p>Review of R99's Care plan, dated 07/05/24 and located under the Care plan tab in the EMR, revealed I entered the facility with 2 skin tears. one on my right calf and one on my right shin, and a stage one pressure ulcer on my gluteal fold. Interventions in the care plan included monitor and report signs of localized infection, such as localized swelling, redness, pain or tenderness, heat at the infected area, purulent drainage, [or] loss of function.</p> <p>During an observation on 07/24/24 at 10:45 AM, Licensed Practical Nurse (LPN)3 provided wound care to R99. LPN3 placed wound care supplies on the floor. The supplies placed on the floor included: Kerlix, four-by-four gauze pads, wound cleanser, Xeroform dressing, Coban, and scissors. The wound on the right leg was cleansed and covered with a small piece of Xeroform, Kerlix gauze, and Coban. The same procedure and supplies were used on the left leg. A protective barrier was not placed under R99's left heel. LPN3 cleansed the heel wound with wound cleanser, and R99 placed her bare foot on the floor. A protective barrier was not placed under R99's feet. At 11:02 AM, LPN3 placed her scissors on the floor. At 11:07 AM, LPN3 used the scissors to cut a piece of Xeroform dressing and then placed the scissors in a Ziplock bag with unused wound care supplies. LPN3 also placed the Xeroform dressing back in the Ziplock bag.</p> <p>During an observation on 07/24/24 at 11:09 AM, LPN3 placed all wound care supplies in the treatment cart.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2024
NAME OF PROVIDER OR SUPPLIER Sunnyview Nursing Home & Apartments		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 E 28th Street Trenton, MO 64683	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 07/24/24 at 11:10 AM, LPN3 stated she should have placed a protective barrier on the ground under her supplies and under R99's feet. LPN3 stated her scissors should have been cleansed after being on the floor and prior to using them again. LPN3 stated the wound care supplies should not have been placed back in the treatment cart after they were placed on the floor. LPN3 stated she needed to throw away the opened Xeroform dressing that she returned to the treatment cart.</p> <p>During an interview on 07/24/24 1:37 PM, the DON stated nurses should have gathered the wound care supplies, introduced themselves to the resident, washed their hands prior to beginning the treatment, and placed a protective barrier under the supplies and under the resident. The DON stated wound care supplies should never be placed on the floor, dirty supplies should not be placed in a bag with clean supplies, and any contaminated items should not be placed back in the treatment cart.</p>