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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675826 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/29/2025 |
| NAME OF PROVIDER OR SUPPLIER Sunset Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 1800 West 9th St Clifton, TX 76634 | |

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) |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews the facility failed to ensure each resident was treated with respect, dignity, and care for 1 of 15 residents (Resident #80) observed for resident rights.</p> <p>The facility failed to ensure Resident #80 was served her meal and provided assistance to eat at the same time as the other residents.</p> <p>The facility failed to ensure that they were engaging Resident #80 while assisting her with lunch.</p> <p>This failure could place residents at risk of lowered self-esteem, depression, and frustration.</p> <p>Findings included</p> <p>Record review of Resident #80's face sheet dated 05/29/25 reflected a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of Dementia (chronic brain degeneration), Edema (excessive fluid retention around parts of the body), pulmonary embolism (lung clots), Epileptic seizures, and Cognitive communication deficit (a generalized inability to understand and communicate due to disease state).</p> <p>Record review of Resident #80's quarterly MDS dated [DATE] revealed no BIMS score indicating no cognition of the individual.</p> <p>Record review of Resident's care plan last updated 12/12/24 stated, Monitor the patient for nonverbal communication, such as facial grimacing, smiling, pointing, crying, and so forth. An approach for psychosocial wellbeing stated, Anticipate needs and observe for non-verbal cues as needed. A note in the care plan dated 04/21/25 stated that Resident #80 is now being assisted with meals post fall on 03/31/25. Resident will be fed by one staff member.</p> <p>Observation on 05/27/25 at 11:37 am in the secured unit dining room revealed RA C sat down next to another resident at the same table as Resident #80 with one plate of food. RA C began feeding the other resident.</p> <p>Observation on 05/27/25 at 11:44 am in the secured unit dining room revealed Resident #80 was rocking back and forth, moaning, and grunting loudly. RA C stated to Resident #80 that she was sorry and to wait because her food was coming soon.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Observation on 05/27/25 at 11:50 am in the secured unit dining room RA C reminded Resident #80 that her food was coming soon and not to touch anyone else's food.</p> <p>Observation at 05/27/25 at 11:55 AM in the secured unit dining room LVN A came over to Resident #80 and stated, Are you starving? I am so sorry honey, let me get your food.</p> <p>Observation at 05/27/25 at 12:05 pm in the secured unit dining room CNA B sat down at the table with Resident #80 and began assisting her with food.</p> <p>Observation at 05/27/25 at 12:05-12:09 pm in the secured unit dining room CNA B and RA C were talking with each other and not engaging the residents while they were assisting them with meals.</p> <p>Observation on 05/28/25 at 11:41 am in the secured unit dining room one resident at the assisted dining table had food. Three other residents were waiting on food.</p> <p>Observation on 05/25/25 at 11:47 am in the secured unit dining room revealed the two residents at the assisted dining table, not including Resident #80, received their food.</p> <p>Observation on 05/25/25 at 11:54 am in the secured unit dining room revealed Resident #80 received her food .</p> <p>Interview with CNA B on 05/27/25 at 2:19 pm she revealed that Resident #80 normally does not wait that long for her food. She stated that because surveyors were in the building they were taking longer to do everything. She stated that sometimes RA C feeds both residents at the same time but did not today because surveyors were in the building. She stated that the outcomes from not serving Resident #80 on time were evident. She could tell Resident #80 was upset and frustrated when she was made to wait.</p> <p>Interview with LVN A on 05/29/2025 at 10:07 am she revealed that she was aware Resident #80 did not receive her food on time yesterday and was frustrated. When she saw Resident #80 getting frustrated, she instructed RA to feed both residents until another caregiver was available to help. She stated that it was important for the caregivers to interact with the residents when feeding them because it made them feel important.</p> <p>Interview with MA D on 05/29/25 at 10:30 am she stated that she does not assist residents with eating at this facility, but she was trained to communicate and engage with the residents. She stated waiting a long time for food would make her upset because it might be cold, and the residents might have felt that way too.</p> <p>Interview with RA C on 05/29/25 at 10:30 am revealed that she did not feed Resident #80 because she was unsure what to do when surveyors were in the building. She realized it took a long time to get Resident #80's food and she recognized that Resident #80 was upset. She stated when she got approval from LVN A that was when she was feeding both residents at the same time. She stated that residents would have felt bad if they did not receive their food on time. She said if it had been her, she would not have liked it.</p> <p>(continued on next page)</p> | | |

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Interview with ADON on 05/29/25 at 11:04 am revealed that it was important for residents to be addressed by the caregiver feeding them. She stated that the CNA's can feed two people at once, as long as there's no cross contamination. She stated that 20 minutes was too long for anyone to wait for their food while others were eating.</p> <p>Interview with DON on 05/29/25 at 11:23 am she revealed that it was ok to feed two people at one time. It was not acceptable for residents to wait more than 5 minutes while others were eating at the same table. She stated that the staff should be talking and engaging the residents while providing any type of care.</p> <p>Interview with ADM at 05/29/25 at 1:55 pm revealed that his expectation was for staff to talk to residents while they were feeding them. He stated it was ok for staff to feed two people at one time. He stated that 15 minutes was too long to wait while others were eating. He stated that in a perfect world all residents at the same table would be fed at the same time. He stated the residents might be upset if they did not get their food on time.</p> <p>Record review of facility policy titled Dignity dated 2001 states, When assisting with care, residents are supposed in exercising their rights. For example, residents are provided with a dignified dining experience.</p> | | |

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| <p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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** Based on observation, interview, and record review the facility failed to use appropriate alternatives prior to installing a side or bed rails, assess the resident for risk of entrapment, review the risk and benefits, and obtain informed consent prior to installation for 3 out of 15 residents (Residents #63, #80, and #100) reviewed for bedrails.</p> <p>The facility failed to assess and get signed consents for Residents #63, #80, and #100 prior to installing bed rails.</p> <p>This deficient practice could affect residents who utilized bed rails by placing them at risk for unintended entrapment of the head, neck, or limbs, restraints, and injuries.</p> <p>The findings included:</p> <p>Record review of Resident #63's face sheet dated 05/29/25 reflected a 72 -year-old male who was admitted to the facility on [DATE] with relevant diagnoses of dementia, cellulitis (major infection of the skin), cognitive communication deficit (a generalized inability to understand and communicate due to disease state), anxiety and insomnia (inability to sleep consistently.)</p> <p>Record review of Resident #63's quarterly MDS dated [DATE] reflected no BIMS score and indicates severe impairment of cognitive skills for daily decision making.</p> <p>Record review of Resident #63's care plan updated 02/12/25 reflected half rails up for bed mobility positioning and transfers.</p> <p>Record review of Resident #63's physician orders reflected no orders for the use of side rails.</p> <p>Record review of Resident #63's assessment reflected no side rail assessment that included informed consent on file for the use of bedrails.</p> <p>An observation on 05/27/25 at 2:09 PM revealed Resident #63 was reclining in his bed with half rails up on the left side of the bed.</p> <p>In an interview on 05/28/25 at 9:37 am with RP for Resident #63 she stated that she was surprised to see the bed rails up. She stated that she was unaware that they had bed rails installed and that the facility had not talked to her about the rails. She revealed that</p> <p>Resident #63 does not even know how to use the remote to the television so she was sure he could not negotiate getting bedrails down.</p> <p>Record review of Resident #100's face sheet dated 05/29/25 reflected a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease with late onset (a condition that causes memory loss), unspecified dementia, adult failure to thrive, and muscle wasting and atrophy (a condition where the muscles degrade over time.)</p> <p>(continued on next page)</p> | | |

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| <p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Record review of Resident #100's quarterly MDS dated [DATE] reflected a BIMS score of 03 indicating severe cognitive impairment.</p> <p>Record review of Resident #100's care plan reflected no mention of bed rails.</p> <p>Record review of Resident #100's clinical physician orders reflected no orders for the use of side rails.</p> <p>Record review of Resident #100's consents reflected no informed consent on file for the use of bedrails.</p> <p>Record review of Resident #100's assessments reflected that there was no assessment completed for the risk of entrapment from bed rails prior to installation.</p> <p>An observation on 05/28/25 10:39 AM revealed Resident #100 was dressed for the day with a hat and shoes on but was lying in bed with eyes closed, hands folded over his chest, and the half rails in the up position on both sides of the bed.</p> <p>Record review of Resident #80's face sheet dated 05/29/25 reflected a [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of Dementia (chronic brain degeneration), Edema (excessive fluid retention around parts of the body), pulmonary embolism (lung clots), Epileptic seizures, and Cognitive communication deficit (a generalized inability to understand and communicate due to disease state).</p> <p>Record review of Resident #80's admission MDS dated [DATE] revealed no BIMS score which indicates a complete loss of cognition.</p> <p>Record review of Resident #80's care plan reflected half rails up for bed mobility positioning and transferring.</p> <p>Record review of Resident #80's clinical physician orders revealed no orders for the use of side rails.</p> <p>Record review of Resident #80's consents revealed no informed consent on file for the use of bedrails.</p> <p>Record review of Resident #80's assessments revealed that there was no assessment completed for the risk of entrapment from bed rails prior to installation.</p> <p>An observation on 05/27/25 02:48 PM revealed Resident #80 was asleep in her bed with half-length bed rails in the up position on both sides at the head of the bed with the bed in the lowest position.</p> <p>An interview on 05/27/25 at 2:19 pm with CNA B revealed that she knew Resident #80 had bed rails up with her bed in the lowest position. She stated these interventions were in place after the resident's previous fall. She stated she did not try to move herself or ambulate independently. She stated the rails were not a risk for Resident #80.</p> <p>(continued on next page)</p> | | |

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| <p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>An interview on 05/29/25 at 10:07 am with LVN A she stated that the admission form had an assessment called side rails that was what any nurse should have filled out for new admissions. She stated she had not admitted anyone recently, so she did not think about checking for that admission assessment. She stated that they are supposed to print and have the family sign the assessment. LVN A stated that if it was not in the electronic record, it would not have been stored anywhere else.</p> <p>An interview on 05/29/25 at 10:30 AM with MA D she stated that bed rails did need consents because the families need to be aware due to the fact that they were considered restraints. She stated that people needed the bed rails but was dependent on her charge nurse to ensure that proper information and consent was obtained to use the rails.</p> <p>An interview on 05/29/25 at 10:43 am with RA C revealed that she was aware some residents used bedrails but thought that they were only supposed to put up one side. She stated that she did not think consent was needed in all situations, but they needed to treat each resident individually. The residents had the right to get up, but normally they would keep the bed in the lowest position with a fall mat before using bedrails.</p> <p>An interview on 05/29/25 at 11:04 am with ADON she stated that she was not sure of the facility policy for bed rails. She stated many residents use side rails to help them turn in bed. She stated she believed they should follow facility policy about the use of bed rails.</p> <p>An interview on 05/29/25 at 11:23 AM with the DON she stated that there was a restraint policy in the admission packet. She stated the signed restraint policy would be considered informed consent for bed rails to be implemented. She revealed that staff should do an assessment for bed rails upon admission and was unsure why they were not completed. She said that residents can be injured if bed rails are not used properly.</p> <p>An interview on 05/29/25 at 01:55 PM with the ADM who stated that there were many different types of bed rails in the facility, but he expects to follow the bed rail policy because he was aware they could be considered restraints. He expected the facility to have informed consents and bed rail assessments on file. He stated that residents could become trapped or injured if used improperly.</p> <p>Review of the facility policy Bed Safety and Rails dated August of 2022 reflected:</p> <p>Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. For the purpose of this policy bed rails include:</p> <p>a.</p> <p>side rails.</p> <p>b.</p> <p>safety rails; and</p> <p>c.</p> <p>(continued on next page)</p> | | |

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| <p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>grab/assist bars.</p> <p>The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.</p> <p>Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted.</p> <p>If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails</p> <p>Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent:</p> <p>The assessed medical needs that will be addressed with the use of bed rails will include.</p> <p>The resident's risks from the use of bed rails and how these will be mitigated.</p> <p>The alternatives that were attempted but failed to meet the resident's needs; and</p> <p>The alternatives that were considered but not attempted and the reasons.</p> |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that all drugs and biologicals used in the facility were labeled in accordance with professional standards, including expiration dates for 1 of 4 medication carts reviewed.</p> <p>During observation of MC A, Resident #16's Artificial Tears had an expiration date of 08/2024.</p> <p>This failure could lead to medication not being effective, and therefore impacting resident health.</p> <p>Findings included:</p> <p>Record review of Resident #16's undated face sheet reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #16 had diagnoses which included chronic kidney disease, hypertensive heart failure, need for assistance with personal care, anxiety disorder, dry eye syndrome unspecified lacrimal gland (dryness of the cornea and conjunctiva caused by a deficiency in tear production), and xeroderma of left upper eyelid (excessively dry skin).</p> <p>Record review of Resident #16's Prescription Order reflected she had been prescribed Natural Tears OTC 0.1 - 0.3% 2 drops to both eyes four times a day as needed for dry eye syndrome of unspecified lacrimal gland.</p> <p>Observation on 05/29/25 at 10:38 AM of MC A revealed Resident #16's Artificial Tears (Natural Tears) had an expiration date of 08/2024.</p> <p>Interview on 05/29/25 at 10:45 AM with RN A revealed the expired Artificial Tears had somehow been missed on MC A. RN A stated the charge nurse was responsible for checking the medication cart each shift, and Pharmacist checked all medication carts and medication rooms once per month. RN A stated an adverse effect of an expired medication was decreased effectiveness.</p> <p>Interview on 05/29/25 at 02:14 PM with the DON who revealed she had been the DON since 2021. She stated the charge nurse should be checking the medication carts for expiration dates before administering them, and pharmacist checks all medications and carts on a monthly basis, and the findings go into a pharmacy report. The DON further stated the Pharmacist and neighborhood manager were responsible for ensuring there were no expired medications on the medication carts. She stated an expired medication might not be therapeutic to a resident if the medication was past the expiration date.</p> <p>Interview on 05/29/25 at 02:37 PM with the Administrator who stated he has worked in the facility for 11 years. The Administrator stated staff should check every shift for expired medications, and certainly before they administer anything. He further stated his expectation was for staff that administer medications to the residents to look and keep an eye out for expired medications and pull it out and do not give it to the resident. An adverse effect of residents receiving an expired medication was it could make them ill, or the medication would not be effective.</p> <p>(continued on next page)</p> | | |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Policy and Procedure for Medication Labeling and Storage dated 2001 reflected, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys.</p> <p>4. For over the counter (OTC) medications in bulk containers the label contains:</p> <ul style="list-style-type: none"> a. the medication name. b. strength. c. quantity. d. accessory instructions. e. lot number; and f. expiration date (if applicable). | | |

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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interviews, and record reviews, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen reviewed for sanitation.</p> <p>The facility failed to dispose of perishable foods in the dry storage pantry and walk in fridge.</p> <p>These failures could place residents at risk for consuming hazardous expired food and developing foodborne illnesses who received food from the kitchen.</p> <p>Findings Included:</p> <p>Observation in the kitchen on 05/27/25 at 9:36 am revealed a bag of white bread with the use by date of 02/26/25.</p> <p>Observation on 05/27/25 in the kitchen at 9:36 am revealed a bag of tortillas with the use by date of 04/18/25.</p> <p>Observation on 05/27/25 in the kitchen at 9:36 am revealed a bag of buns with the use by date of 05/07/25.</p> <p>Observation on 05/27/25 in the kitchen at 9:36 am revealed a tray of four mayo bottles all marked with the expiration date of 04/29/25.</p> <p>In an interview with [NAME] E on 05/29/25 at 1:22 pm she revealed that she had been trained on what to do with expired foods. She stated that expired foods must be thrown away. There was a 3-day limit on cooked food and the expiration date could have been sooner depending on when it arrived. She stated that when they received the items, they labeled it with date they received and date of expiration. She checked for expired foods daily. She stated expired foods could have made residents sick.</p> <p>In an interview with DS F on 05/29/25 at 2:03 pm, she revealed that the expectation was for her staff to open it and label it. Expired foods should have automatically been thrown away and then notified a manager. She stated freezer and pantry items expired 6 months after receiving it. She stated managers were responsible for ensuring there were not expired items in the kitchen. She said residents could get sick if they eat expired foods.</p> <p>In an interview with DON on 05/29/25 at 2:16 pm, she revealed that expired food should have had a use by date, was stored in the proper place, and if expired should have been thrown away immediately. She stated that staff and managers had a check off system for foods. She stated they routinely should have gone through the pantry to look for expired foods. She stated residents could get ill if they eat expired foods.</p> <p>In an interview with the ADM on 05/29/25 at 2:38 pm, he stated that expired foods should have been thrown out. The policy was every food item needed an expiration date and when it reaches that date it should have been thrown out. They should have been checking for expired foods after every shift. He stated residents could get ill if they eat bad food.</p> <p>(continued on next page)</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675826 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 05/29/2025 |
| NAME OF PROVIDER OR SUPPLIER Sunset Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 1800 West 9th St Clifton, TX 76634 | |
| 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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Record Review of facility policy titled Food Receiving and Storage dated November 2022 stated,</p> <p>7. Refrigerated foods are labeled, dated, and monitored so they are used by their use-by date, frozen, or discarded.</p> <p>Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates.</p> | | |