STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009302	A. BUILDING: _____ B. WING _____	10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOME	418 WASHINGTON STREET QUINCY, IL 62301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.1210b) 300.1210c) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 These requirements are not met as evidenced by: Based on interview and record review the facility failed to ensure a fall prevention pressure alarm was in working order for one of four residents (R86) reviewed for falls in a sample of 29. This failure resulted in R86 sustaining a fall with a fractured left hip when R86's pressure alarm failed to sound and alert staff that R86 was ambulating without assistance. Findings include: A Falls Management Program dated 7/2017 states, "Interdisciplinary Team: An interdisciplinary team will meet on a regular basis to discuss individuals who have had a history or are at high risk of falling and develop a plan to lower the risk potential for future falls." This policy states," Prevention tools may include assessments, education, medication reviews, environmental changes, and the use of fall mats and alarms. An Alarm Reduction Program policy states, "Alarms may malfunction, be removed, or lose their effectiveness over time." 1. R86's 8-3-22 Minimum Data Set (MDS) assessments documents R86 is moderately cognitively impaired and requires extensive assistance of one person for bed mobility, transfers, walking in room, dressing, toileting, and personal hygiene. R86's Fall Risk assessment dated 5/3/22 documents R86 is at risk for falls. R86's care plan for transfers dated 7/26/22	S9999		

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S9999	Continued From page 2 documents R86 requires the extensive assistance of one person with a transfer belt and a wheeled walker. R86's fall investigation report dated 8/20/22 to 8/23/22 documents that on 8/20/22 while R86 was in her room sitting in a chair, R86 stood up without calling for assistance, walked to the door without using her walker, then turned around to walk back when R86 fell to the floor causing her left leg to rotate out. This report documents that R86 was using a pressure alarm in her chair to alert staff when R86 gets up without assistance, however, on 8/20/22 this pressure alarm was not functioning, and staff were not alerted. The report documents that staff did not know R86 was ambulating without assistance until after R86 fell and was heard yelling for help. This report documents R86 was sent emergently to the hospital where she was diagnosed with a fractured left hip. R86's hospital X-ray report dated 8/20/22 documents R86 sustained a "Comminuted mildly angulated intertrochanteric fracture of the proximal left femur." On 10/25/22 at 12:24 PM V4 (Unit Manager) stated that R86 has a history of falls. V4 stated that as a fall prevention measure, the IDT placed a pressure alarm in R86's chair which alarms each time R86 gets up without assistance. V4 stated if R86's alarm sounds, staff rush to R86's room to make sure they assist R86, so she doesn't fall. V4 verified that on 8/20/22, R86's pressure alarm did not sound when R86 got up from the chair to walk around her room. V4 stated there is no documentation for when staff last verified that R86's pressure alarm was properly functioning. V4 stated the facility did not have a	S9999		

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S9999	Continued From page 3 policy for staff to regularly check the functioning of residents' pressure alarms on a per shift or even a daily basis. (A)	S9999		