DEPARTMENT OF HEAD	LTH AND HUMA	N SERVICES			<b>CENTERS FOR MEI</b>	DICARE & MEDICAID SERVICES			
					AND TRANSMITTAL	ID: EUPC			
	PART I -	TO BE COMPI	LETED BY T	THE STAT	<b>FE SURVEY AGENCY</b>	Facility ID: 00145			
1. MEDICARE/MEDICAID PROV (L1) 245379		3. NAME AND AI (L3) KENYON S	UNSET HOM	E		<ul> <li>4. TYPE OF ACTION: <u>7</u>(L8)</li> <li>1. Initial 2. Recertification</li> </ul>			
2.STATE VENDOR OR MEDICAL (L2) 779040600	ID NO.	(L4) 127 GUNDE (L5) KENYON, N		L VAKD	(L6) <b>55946</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other			
5. EFFECTIVE DATE CHANGE (L9)	OF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY       01 Hospital     05 HHA     09 ESRI			<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint			
6. DATE OF SURVEY     12       8. ACCREDITATION STATUS:       0 Unaccredited     1 TIC       2 AOA     3 Oth		02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30			
11LTC PERIOD OF CERTIFICAT	ΓΙΟΝ	10.THE FACILITY	IS CERTIFIED	AS:					
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:			
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit			
12. Total Facility Beds	<b>38</b> (L18)	•	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director IF)8. Patient Room Size 9. Beds/Room			
13.Total Certified Beds	<b>38</b> (L17)		npliance with Pro ents and/or Appl		* Code: A*	(L12)			
14. LTC CERTIFIED BED BREAK	KDOWN	•			15. FACILITY MEETS				
18 SNF 18/19 SI 38	NF 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY R	EMARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION	DATE):					
See Attached Remarks									
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:			
Gary Nederhoff, U	nit Supervisor	1	2/30/2014	(L19)	Anne Kleppe, Enforcement Specialist 03/12/2014				
I	PART II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY			
<ol> <li>DETERMINATION OF ELIGI</li> <li><u>X</u> 1. Facility is Eligible</li> </ol>			IPLIANCE WIT HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) : :			
2. Facility is not Elig	gible (L21)								
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION:	(L30)			
OF PARTICIPATION	BEGINNINC	<b>J</b> DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY			
12/01/1986					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety			
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminatio	m			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			04-Other Reason for Withdrawal	07-Provider Status Change			
	A. Suspension	i of Admissions.	(L44)			00-Active			
(L27)	B. Rescind Su	spension Date:							
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	L DATE					
	(L32)	12/26/2013		(L33)	DETERMINATION APPI	ROVAL			

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

### CCN = 24-5379

At the time of the extended survey completed November 1, 2013, the facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiencies were found to be constituted immediate jeopardy (Level J), whereby corrections were required as evidenced by the attached CMS-2567.

On December 30, 2013, a Post Certification Revisit (PCR) was completed by the Department of Health and on December 16, 2013, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the November 1, 2013 survey, effective December 11, 2013. Refer to the CMS 2567B for both health and life safety code.

Effective December 11, 2013, the facility is certified for 38 skilled nursing facility beds.

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

### CCN = 24-5379

At the time of the extended survey completed November 1, 2013, the facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiencies were found to be constituted immediate jeopardy (Level J), whereby corrections were required as evidenced by the attached CMS-2567.

On December 30, 2013, a Post Certification Revisit (PCR) was completed by the Department of Health and on December 16, 2013, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the November 1, 2013 survey, effective December 11, 2013. Refer to the CMS 2567B for both health and life safety code.

Effective December 11, 2013, the facility is certified for 38 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5379

March 12, 2014

Ms. Chelsea Ugland, Administrator Kenyon Sunset Home 127 Gunderson Boulevard Kenyon, Minnesota 55946

Dear Ms. Ugland:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 11, 2013, the above facility is certified for:

38 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 38 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Are Klegepe

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

February 2, 2014

Ms. Chelsea Ugland, Administrator Kenyon Sunset Home 127 Gunderson Boulevard Kenyon, Minnesota 55946

RE: Project Number S5379023

Dear Ms.. Ugland:

On November 25, 2013, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective November 30, 2013. (42 CFR 488.422)

On November 25, 2013, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

• Civil Money Penalty for the deficiency cited at F225, effective October 26, 2013. (42 CFR 488.430 through 488.444)

• Civil Money Penalty for the deficiency cited at F226, effective November 1, 2013. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on November 1, 2013. Conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On December 30, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 16, 2013, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on November 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 11, 2013. We have determined, based on our visit, that your facility has obtained substantial compliance with, but not totally corrected, the deficiencies issued pursuant to our extended survey, completed on November 1, 2013, as of December 30, 2013. Since the deficiency is considered to be in substantial, this Department is discontinuing the Category 1 remedy of state monitoring effective December 30, 2013.

Kenyon Sunset Home February 2, 2014 Page 2

However, as we notified you in our letter of November 25, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 1, 2013.

In addition, this Department is recommending to the CMS Region V Office the following actions related to the imposed remedies in our letter of November 25, 2013:

• Civil Money Penalty for the deficiency cited at F225, effective October 26, 2013 remain in effect. (42 CFR 488.430 through 488.444)

• Civil Money Penalty for the deficiency cited at F226, effective November 1, 2013 remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

### Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5379r14.rtf

### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245379	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 12/30/2013
Nam	e of Facility		Street Address, City, State, Zip Code	
KE	NYON SUNSET HOME		127 GUNDERSON BOULEVARI KENYON, MN 55946	D

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Da	te	(Y4)	ltem		(Y5)	Date
ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(ii	Correction Completed 12/30/2013 ii), (c)(2) -	ID Prefix Reg. # LSC	F0226 483.13(c)	Com 12/30	ection pleted D/ <b>2013</b>		ID Prefix Reg. # LSC	F0280 483.20(d)(3), a	483.10(k	Correction Completed 12/30/2013
ID Prefix Reg. # LSC	F0309 483.25	Correction Completed 12/30/2013		F0312 483.25(a)(3)	Com	ection pleted D/2013			F0329 483.25(I)		Correction Completed 12/30/2013
ID Prefix Reg. # LSC	483.30(a)	Correction Completed 12/30/2013	ID Prefix Reg. # LSC	F0356 483.30(e)	Com	ection pleted / <b>2013</b>		ID Prefix Reg. # LSC	F0425 483.60(a),(b)		Correction Completed 12/30/2013
	F0520 483.75(o)(1)	Correction Completed 12/30/2013			Com	ection pleted		ID Prefix Reg. # LSC			Correction Completed
Reg. #			Reg. #		Com	ection pleted		D //			
Reviewed	By Rev	viewed By	Date:	Signature	of Surveyo	r:				Date:	
State Agen Reviewed CMS RO		IM/GPN viewed By	02/02/20 Date:		of Surveyo		i94			Date:	12/30/2013
Followup	o Survey Comple 11/1/201			Check for any Uncorrecte					Summary of the Facility?	YES	NO

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245379	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 12/30/2013
Name	of Facility		Street Address, City, State, Zip Code	
KE	NYON SUNSET HOME		127 GUNDERSON BOULEVARD KENYON, MN 55946	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Ite	m	(Y5)	) Date	(Y4)	ltem		(Y5)	Date	(Y4)	ltem	(	(Y5) I	Date
Re	efix <b>F0225</b> g. # <mark>483.13(c)</mark> SC	(1)(ii)-(iii), (c)(2) -	Correction Completed _12/30/2013 -(4)		ID Prefix Reg. # LSC	F0226 483.13(c)		Correction Completed 12/30/2013		ID Prefix Reg. # LSC	F0280 483.20(d)(3), 48:	3.10(k)(2)	Correction Completed 12/30/2013
Re	efix <b>F0309</b> g. # <b>483.25</b> SC		Correction Completed 12/30/2013		ID Prefix Reg. # LSC	F0312 483.25(a)(3)		Correction Completed 12/30/2013			F0329 483.25(l)		Correction Completed 12/30/2013
	efix <u>F0353</u> g. # <mark>483.30(a)</mark> SC		Correction Completed _12/30/2013		ID Prefix Reg. # LSC	F0425 483.60(a),(b)		Correction Completed 12/30/2013		ID Prefix Reg. # LSC	F0520 483.75(o)(1)		Correction Completed 12/30/2013
			-		Reg. #			Correction Completed					
	g. #		_		ID Prefix Reg. # LSC					Reg. #			
Reviewe	d By	Reviewed	Ву	Dat	e:	Signature o	f Surve	yor:				Date:	
State Ag	ency	MM/C	GPN	02/	/02/201	.4	19	694				12/3	0/2013
Reviewe CMS RO	d By	Reviewed	Ву	Dat	e:	Signature o	f Surve	yor:				Date:	
Followu	p to Survey C	ompleted on: 1/1/2013									a Summary of to the Facility?	YES	NO

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245379	<b>(Y2) Multiple Constru</b> A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 12/16/2013
Name	of Facility		Street Address, City, State, Zip Code	
KE	NYON SUNSET HOME		127 GUNDERSON BOULEVARD KENYON, MN 55946	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item		(Y5)	Date	(Y4)	ltem	(Y5)	Date	(Y4	) Item		(Y5)	Date
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			12/04/2013		ID Prefix		12/05/2013		ID Prefix			12/11/2013
Reg. #	NFPA 101				Reg. #	NFPA 101			Reg. #	NFPA 101		
LSC	K0018				LSC	K0050	-		LSC	K0071		_
								-				
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			10/31/2013		ID Prefix		-		ID Prefix			
-	NFPA 101				Reg. #		-		Reg. #			_
LSC	K0147				LSC		-		LSC			_
			Correction				Correction					Correction
			Completed		ID Drefit		Completed		ID Drafiv			Completed
ID Prefix							-		ID Prefix			_
Reg. #					Reg. #		-		Reg. #			_
LSC					LSC		-		LSC			_
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
							-					
Reg. #					Reg. #		-		Reg. #			_
					200		-	+				_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix			Completed		ID Prefix				ID Prefix			_
Reg. #					Reg. #				Reg. #			
LSC							-					
				1				+				
Reviewed By	Review	ved E	3y	Da	ite:	Signature of Surve	eyor:				Date:	
State Agency	/ MM	/PS	5	02	2/02/20	14 25	822				12/1	6/2013
Reviewed By	Review	/ed E	3y	Da	ite:	Signature of Surve	eyor:				Date:	
CMS RO												
Followup to	Survey Completed on:					Check for any	Uncorrected	Defic	iencies. Was	a Summary of		
	10/30/2013					•				to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

February 2, 2014

Ms. Chelsea Ugland, Administrator Kenyon Sunset Home 127 Gunderson Boulevard Kenyon, Minnesota 55946

Re: Enclosed Reinspection Results - Project Number S5379023

Dear Ms. Ugland:

On December 30, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 1, 2013, with orders received by you on November 27, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

## Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility Licensing and Certification File

5379r14lic.rtf

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245379	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 12/30/2013
Name	of Facility		Street Address, City, State, Zip Code	
KE	NYON SUNSET HOME		127 GUNDERSON BOULEVARD KENYON, MN 55946	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(	Y5) Date	(Y4) Item	(Y:	5) Date	(Y4) Item	(Y5)	Date
ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(iii), (c)(2	Correction Completed 12/30/2013 2) - (4)		F0226 483.13(c)	Correction Completed 12/30/2013	ID Prefix Reg. # LSC	F0280 483.20(d)(3), 483.10(k)	Correction Completed 12/30/2013
ID Prefix Reg. # LSC	F0309 483.25	Correction Completed 12/30/2013		_F0312 483.25(a)(3)	Correction Completed 12/30/2013		F0329 483.25(I)	Correction Completed 12/30/2013
ID Prefix Reg. # LSC	F0353 483.30(a)	Correction Completed 12/30/2013		F0425 483.60(a),(b)	Correction Completed 12/30/2013	ID Prefix Reg. # LSC	F0520 483.75(o)(1)	Correction Completed 12/30/2013
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Reg. #		
Reviewed By		-	Date:	Signature of Surv	-		Date:	
State Agency			02/02/20		9694			/30/2013
Reviewed By CMS RO	v Reviewo	ed By	Date:	Signature of Surv	/eyor:		Date:	
Followup to	Survey Completed on: 11/1/2013					eficiencies. Was (CMS-2567) Sent		NO NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

		ND TRANSMITTAL		ID: EUPC			
1. MEDICARE/MEDICAID PROVIDER N         (L1)       245379         2.STATE VENDOR OR MEDICAID NO.         (L2)       779040600         5. EFFECTIVE DATE CHANGE OF OWN	0.	<ol> <li>NAME AND ADI (L3) KENYON SU (L4) 127 GUNDEI (L5) KENYON, M</li> <li>PROVIDER/SUF</li> </ol>	DRESS OF FACILI J <b>NSET HOME</b> RSON BOULEV IN	TY ARD	(L6) <b>55946</b>	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit	acility ID: 00145 <u>2 (</u> L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
(L9) 6. DATE OF SURVEY 11/01. 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2013 (L34)	01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After Con FISCAL YEAR ENDING 09/30	·
<ul> <li>11. LTC PERIOD OF CERTIFICATION</li> <li>From (a): To (b):</li> <li>12. Total Facility Beds</li> <li>13. Total Certified Beds</li> <li>14. LTC CERTIFIED BED BREAKDOWN</li> </ul>	<b>38</b> (L18) <b>38</b> (L17)	B. Not in Com	ce With equirements	1	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B 15. FACILITY MEETS	6. Scope of Servic 7. Medical Direct	or
18 SNF 18/19 SNF 38 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARK     See Attached Remarks     17. SURVEYOR SIGNATURE     Marietta Lee, HFE	E NE II	Date :	12/13/2013	(L19) E <b>GIONAI</b>	18. STATE SURVEY AGENCY AP <u>Kate JohnsTon, Enfo</u>	orcement Specialis	Date: <u>st</u> 12/24/2013 (L20)
19. DETERMINATION OF ELIGIBILITY        1. Facility is Eligible to Par        2. Facility is not Eligible			IPLIANCE WITH C ITS ACT:	CIVIL		ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA	1513)
22. ORIGINAL DATE OF PARTICIPATION 12/01/1986 (L24) 25. LTC EXTENSION DATE: (L27)	23. LTC AGREEMI BEGINNING I (L41) 27. ALTERNATIVI A. Suspension o B. Rescind Susp	DATE E SANCTIONS of Admissions:	<ol> <li>LTC AGREEME ENDING DATE</li> <li>(L25)</li> <li>(L44)</li> </ol>		26. TERMINATION ACTION: <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure         02-Dissatisfaction W/ Reimburseme         03-Risk of Involuntary Termination         04-Other Reason for Withdrawal	0 <u>INVOLUNT</u> 05-Fail to Me ont 06-Fail to Me <u>OTHER</u>	.30) <u>ARY</u> bet Health/Safety bet Agreement Status Change
28. TERMINATION DATE:	(L28)	. INTERMEDIARY/C 03001	(L45) ARRIER NO.	(L31)	30. REMARKS		
31. RO RECEIPT OF CMS-1539		DETERMINATION (	DF APPROVAL DA		DETERMINATION APPRO	WAL	

### CCN=245379

C&T REMARKS - CMS 1539 FORM

At the time of the extended survey completed November 1, 2013, the facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiencies were found to be constituted immediate jeopardy (Level J), whereby corrections were required as evidenced by the attached CMS-2567.

STATE AGENCY REMARKS

We also verified that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Therefore, this Department is imposing the following remedy:

-State Monitoring effective November 30, 2013. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

-Civil Money Penalty for the deficiency cited at F225, effective October 26, 2013. (42 CFR 488.430 through 488.444) -Civil Money Penalty for the deficiency cited at F226, effective November 1, 2013. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7011 2000 0002 5147 5243

November 25, 2013

Ms. Chelsea Ugland, Administrator Kenyon Sunset Home 127 Gunderson Boulevard Kenyon, Minnesota 55946

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5379023

Dear Ms. Ugland:

The above facility was surveyed on October 28, 2013 through November 1, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

## PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

# THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive Southeast Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility Licensing and Certification File

5379s14lic.rtf

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	, , , , , , , , , , , , , , , , , , , ,	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	245379	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	11/01/2013
AIVIE OF PI	ROVIDER OR SUPPLIER			27 GUNDERSON BOULEVARD	. •
ENYON	SUNSET HOME	,		ENYON, MN 55946	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
	Minnesota Departmen 28-November 1, 2013 Immediate Jeopardy facility's failure to resp of mistreatment/ abus potential for harm or o	ey was conducted by the nt of Health on October 8. The survey resulted in an (IJ) at F225 related to the bond to resident allegations we which resulted in the high death. Facility staff were 0/30/13, at 5:20 p.m. for the			
	IJ that began on 10/2 on 10/31/13, at 4:30 p non-compliance rema	6/13. The IJ was removed			
		nce. Your signature at the le of the CMS-2567 form will	12/09/13 -SPN		
	revisit of your facility r validate that substant	ceptable POC an on-site nay be conducted to al compliance with the attained in accordance with		\$	
	483.13(c)(1)(ii)-(iii), (c INVESTIGATE/REPO ALLEGATIONS/INDIV	RT	F 225	F 225	
	been found guilty of a			Kenyon Sunset Home strives to ensure that each resident's allegation of abuse, neglect,	
	had a finding entered registry concerning ab of residents or misapp	by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property;		mistreatment or misappropriation of their property is reported	on .
	court of law against ar indicate unfitness for s	edge it has of actions by a n employee, which would service as a nurse aide or e State nurse aide registry		immediately to facility Administrator and person in cha	rge.
(!)	helsea R. Ug	UPPLIER REPRESENTATIVE'S SIGNATURE	· · · · · · · · · · · · · · · · · · ·	TITLE Acting Pamin is tractar excused from forrecting providing it is determined th	(x6) date V 1715/12

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE S COMPLE	
1		245379	B. WING		in the second seco	11/0 <i>*</i>	1/201
NAME OF P	ROVIDER OR SUPPLIER	1			STREET ADDRESS, CITY, STATE, ZIP CODE		
					127 GUNDERSON BOULEVARD		
KENYON	SUNSET HOME			1	KENYON, MN 55946		
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F 225	Continued From pag	e 1	F	225	1) R3 and R6 comprehensive		
	or licensing authoriti	es.			assessment and care plan have		**
	The facility must one	ure that all alleged violations			been reviewed regarding abuse	and	
		nt, neglect, or abuse,			neglect allegations. R31 has bee	n	
	including injuries of u	unknown source and			discharged to home. Corrective		
		esident property are reported diministrator of the facility and			action was put in place on Octob	her	
		ccordance with State law			30, 2013. Kenyon Sunset Home		
	•	procedures (including to the			policy requires that all alleged		
	State survey and cer	tification agency).					
	The facility must hav	e evidence that all alleged			violations involving resident		
	violations are thorough	ghly investigated, and must			mistreatment, neglect, and abus	se,	
	prevent further poter				injuries of unknown source and		
	investigation is in pro	ogress.			misappropriation of property be	1)	
-	The results of all inve	estigations must be reported			reported immediately to the		
	to the administrator of				administrator, person in charge	and	
· .		o other officials in accordance ling to the State survey and			appropriate state agencies and 2		r.
		within 5 working days of the			thoroughly investigated within fi		
		leged violation is verified			days with the investigative resul		
:	appropriate correctiv	e action must be taken.					
					reported to the administrative st		
					and state officials as required. If	the	
		Γ is not met as evidenced			alleged violation is verified,		
	by: Based on observation	on, interview and document			appropriate corrective action wi	11	
-	review, the facility fai	led to immediately report to			be taken. The facility intervenes	to	
		mediately report to the			prevent further potential abuse		
		ency, complete a thorough ed to protect 3 of 5 residents			while the investigation is in proc	ess	
	(R31, R3 and R6) rev	viewed for abuse/neglect			and ensures that residents are sa		
		ted being afraid of a nursing					
		g the nursing assistant aighboring resident (identified					
		ing cares. Even though this					
		as reported to facility staff					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED. AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 245379 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON SUNSET HOME KENYON, MN 55946 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2) All Kenyon Sunset Home F 225 Continued From page 2 F 225 residents residing in the facility will following the incident, the facility did not immediately act upon the report and did not be updated on Vulnerable Adult protect R31 or R3 from further potential abuse. policy and procedures. Residents During this time the identified nursing assistant (NA)-E continued to work with these residents for will also be updated on how to several more days before the survey agency report and who to report to and brought this to the facility's attention, at which types of abuse (example neglect, time NA-E had been suspended from work while an investigation was conducted. The findings abuse, mistreatment, etc.). resulted in an Immediate Jeopardy (IJ)situation for 1 of 5 residents (R3) reviewed for allegations 3) Kenvon Sunset Home staff has of abuse. In addition, all other residents remained at risk of potential harm, verbal abuse, been re-educated on Vulnerable that is not immediate jeopardy, as NA-E had the Adult policy, procedures and how potential to work unsupervised with all residents and who to immediately report to in the facility. when an allegation of abuse occurs. The immediate jeopardy began on 10/26/13, when a licensed practical nurse (LPN)-A was 4) To ensure all employees' made aware of an allegation of abuse and failed to internally report, investigate, report to the understanding, knowledge and designated State agency (Office of Health Facility compliance with these policies, Complaints-OHFC), and protect the involved residents. Consequently, the alleged perpetrator Department Managers will perform (NA-E) continued working with the residents for on a weekly basis for a six month several days. The administrator, director of duration and thereafter quarterly as nursing, and licensed social worker (LSW) were notified of the immediate jeopardy on 10/30/13 at needed review and questioning of 5:20 p.m. The immediate jeopardy was removed on 10/31/13 at 4:30 p.m. however, policies and procedures. noncompliance remained at the lower scope and Completion of mandated yearly inseverity level of an F-a pattern, which indicated services will be scheduled on a no actual harm with potential for more than minimal harm that is not immediate jeopardy. monthly basis for all employees. All in-services will include a discussion Findings include: R3 was interviewed on 10/28/13 at 2:54 p.m. During the interview, R3 was asked and review of these policies. whether or not she or anyone else in the facility had been abused. R3 had immediately

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Event ID: EUPC11

Facility ID: 00145

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245379	B. WING		11/01/2013	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				127 GUNDERSON BOULEVARD		
KENYON	SUNSET HOME			KENYON, MN 55946	*	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 225	interview with R3 it w overheard a conversa R31 who lived next d that NA-E told R31 to if she didn't, the staff	e 3 he question and on further as learned that R3 had ation between a NA-E and oor to her. R3 went on to say get her own blouse on and would come back and GET loud and threatening tone of	F 22	5) Completion date: J <del>anuary</del> 2 <del>014.</del>	14, Десеть 11, 2013 лери	
	voice. R3 said she'd "lazy." NA-E had con went into R3's room a NA-E "was at me." R3 her bedroom and had threatening tone, "Thi	also heard NA-E call R31 npleted cares for R31 and at which time R3 stated that 3 stated NA-E had entered I stated, in a sarcastic and is is the third time I have d NA-E had made that				
	said that because of I asked NA-E to help w was upset by the way didn't mention my bac	d requested more had used her last one. R3 NA-E's tone, she hadn't vash her back. R3 stated, "I she [NA-E] was talking so I ck. She [NA-E] was so angry out of here storming. I don't				
	know why she was so spoken to licensed pr her concerns on 10/20 done. R3 then stated member-A had stoppe added, "They [referen	andry." R3 stated she had actical nurse (LPN)-A about 6/13 but nothing had been her daughter family (F) ed in to see her today and the to the director of nursing ractical nurse (LPN)-B] are				
	on it today. The boss down here and talked (F-A) was here and he be a tattle tale but I di [NA-E] took. I tried ha	[reference to DON] came to me and my daughter eard the story. I didn't like to dn't like the action she rd to dress faster, but I can't				
	NA-E was acting, she	d that because of the way had tried to dress faster on d not upset NA-E when she				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 245379 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON SUNSET HOME KENYON, MN 55946 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 4 F 225 R3's record was reviewed. The record identified that R3 had been admitted to the facility on 9/25/13, with diagnoses which included: macular degeneration (blindness), chronic pain, and depression. An admission Minimum Data Set (MDS) assessment dated 10/1/13, identified R3's cognitive status as alert and oriented. The MDS also indicated R3 required limited assistance with activities of daily living skills (ADLs), but required extensive assistance with dressing and toileting needs. R3's temporary care plan (one developed on admission and used until the comprehensive care plan is completed on day 21 after admission) dated 9/25/13, identified problems for R3 including limited mobility related to macular degeneration (blindness), and falls related to macular degeneration, and potential for medications side effects. During interview with the DON on 10/30/13 at 2:35 p.m., the DON verified that on Monday 10/28/13, R3's family (F-A) had come to the facility to visit and when R3 told F-A what had happened on Saturday 10/26/13 about the way she and R31 had been treated, F-A had immediately talked to LPN-B who was on duty and began to inform LPN-B of what had happened on the prior Saturday. According to the DON, as F-A and R3 began describing the incident, LPN-B had summoned the director of nursing (DON) to listen in about the incident at the same time. When the DON arrived, R3 and F-A had described the allegation of abuse by NA-E that had occurred on Saturday 10/26/13. The DON stated R3 had told her that she had overheard an angry conversation between R31 and NA-E. R3 had told her she felt NA-E was angry when caring for R31, and was still angry when she had approached R3 to provide care.

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

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STATEMENT OF DEFICIEN AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRU	UCTION		(X3) DATE SURVEY COMPLETED
1		245379	B. WING				11/01/2013
NAME OF PROVIDER OF		L		127 GUNDE	DRESS, CITY, STATE, ZIP CODE ERSON BOULEVARD MN 55946		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
The DON was ang curtain ir spoken w having m informed and belit she had reported interview neither s the admi allegation had beer R3 and F NA-E, an continue two resid verified th facility, a criteria for During an licensed unaware LPN-A, L the LSW, 1:40 p.m. stated the The LSW record of to indicat situation. of NA-E h to the resi	y and that N R3's room. with NA-E ye et with R3 a NA-E her be ling to R31 a not documer by R3 nor ha with NA-E. The nor LPN- histrator or the s. In addition a no interven 31 from pote d that NA-E working un-s ents and oth hat she was nd had not fe r reporting. In interview o social worke of the allege PN-B and the the LSW we the LSW so of the alleged be how the D0 The LSW so aving had is idents in the yeat two previous con- the the solution of the solution the the alleged be aving had is idents in the yeat two previous con- the the solution the yeat two previous con- the two previous con- the two previous con- two previous con-two previous con- two previous con- two previous con- two pre	A 5 R3 kept repeating that NA-E A-E had torn the privacy The DON stated she had sterday (10/29/13) after and her family, and had shavior had been tormenting and R3. The DON confirmed the d he alleged abuse ad she documented the The DON verified that B had immediately informed the State agency about the bon, the DON verified there tions put in place to protect ential ongoing abuse by had been allowed to supervised, caring for these ers in the facility. The DON new to her position at the eff R3's allegation met the abuse R3 had reported to a buse R3 had reported to a buse R3 had reported to a buse R3 had reported to a component to speak to the DON. At proached the surveyor and addressed the situation." re was no documented ncident, nor documentation DN had addressed the tated she had been aware sues with how she speaks past, and stated that NA-E rious warnings in the past ude behavior toward	F	225			
	le for staff tr	Iso stated she was aining regarding issues	<u></u>	Facility ID: 001	45	If continu	ation sheet Page 6 of 45

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 245379 11/01/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 127 GUNDERSON BOULEVARD KENYON SUNSET HOME KENYON, MN 55946 SUMMARY STATEMENT OF DEFICIENCIES iD PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 225 Continued From page 6 F 225 related to respect, dignity, and confidentiality, and that this training occurred at orientation and annually. She stated the last annual training had occurred on 3/20/13, and that NA-E had attended. On 10/30/2013 at 4 p.m., F-A was called by the surveyor and questioned regarding the alleged abuse incident reported by R3 that occurred on Saturday, 10/26/13. F-A stated when R3 had told her on Monday morning (10/28/13) about the incident that had occurred on Saturday, she (F-A) had immediately called for the LPN on duty (LPN-B) to discuss the matter. F-A stated when LPN-B was informed of the incident that had occurred on Saturday, LPN-B had asked the DON to also listen to F-A's concern with how R3 and R31 been treated on Saturday. F-A went on to say that the DON had made the comment that they "would take care of it." F-A said she had called the facility social worker on Tuesday 10/29/13 to clarify some of the events of the alleged abuse told to her by R3. F-A stated that during that phone call F-A had told the social worker that the family had been working hard to get R3 to trust the staff at the nursing home so R3 would ask for help versus trying to do things on her own, due the potential of R3 getting injured. In addition, F-A stated R3 had made the comment that she had been labeled as "lazy" and that the comment had really bothered R3 greatly. On 10/30/2013 at 4:30 p.m., LPN-B was interviewed in regards to the alleged abuse regarding R3 and R31. LPN-B stated she had not worked the weekend when the incident had happened, but had been called to R3's room on Monday 10/28/13 between 9:00 a.m. and 10 a.m. at which time R3 and F-A began to tell her what

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Facility ID: 00145

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245379	B. WING	· · · ·	· 1	1/01/2013
	ROVIDER OR SUPPLIER	L	1	STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON, MN 55946		
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F 225	that R3 reported that had been "slow" and could get her cares de had reported that whe for R31 she gone in to cares. LPN-B said R3 walked into R3's room upset and had a nega said R3 reported that comment, "If you were residents] so lazy or s for R3. LPN-B said as about the incident, LP DON so she could als allegations of abuse. I with R3 and F-A, with	urday 10/26/13. LPN-B said NA-E had told R31 that she if R31 wasn't so "lazy" they one quicker. LPN-B said R3 on NA-E had finished cares o help R3 with morning had reported when NA-E n, R3 felt NA-E appeared tive attitude toward her, and NA-E had made the	F 225		· · · · · · · · · · · · · · · · · · ·	
	a.m., LPN-A stated N/ 10/26/13, following pri- R3, that R3 was upset (NA-E) to provide care having spoken to R3 a aware of the resident's had treated R31 and f allegation had not beet the DON, LSW or adm confirmed the incident the State agency, that investigation, nor had protective intervention not think R3's complai reporting.	by ision of care for R31 and t and reluctant to allow her e. LPN-A acknowledged and having been made s concerns about how NA-E herself. LPN-A verified the minimediately reported to hinistrator, and LPN-A had not been reported to LPN-A had not initiated an LPN-A implemented any s for R3 or R31. LPN-A did nts met the criteria for				
		vas reviewed. NA-E had 2008 to 2009, had taken a lete Event ID: EUPC		cility ID: 00145 If co		eet Page '8 of 45

TATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING		OMB NO: 0938-03 (X3) DATE SURVEY COMPLETED	
		245379	B. WING		11/01/2013	
	ROVIDER OR SUPPLIER	L	127	REET ADDRESS, CITY, STATE, ZIP CODE ' GUNDERSON BOULEVARD NYON, MN 55946		
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F 225	Continued From page		F 225			
		n rehired in 2010. NA-E's ons dated 10/7/11 identified				
	•	t get frustrated when things			· · ·	
	-	aluation dated 11/20/12				
	included, "Stay out of	the 'drama' keeping				
	•	s personnel record also				
		ed incident dated 9/21/11,				
		nad complained of rough The incident documentation				
		tated, "We are short staffed				
		ad been verbally counseled				
		onsiderate of residents. A				
		rt dated 2/1/12, indicated				
		d the necessary personal				
		that the resident could be				
		go to an appointment. The IA-E to apologize to the				
	-	on to resident needs. The				
		rts did not indicate NA-E				
		itional training on resident		<u>.</u>		
	•	ent, or communication				
	skills. On 10/31/13 at					
		that no additional concerns				
	identified.	ated residents had been				
				·		
a de la companya de l		dated 10/15/13, identified				
	the resident as having					
		atus) of 15. The MDS also				
	indicated the resident assistance with all AD					
	assistance with an AD	LU.				
	R31 was interviewed of	on 10/30/13 at 5:00 p.m.				
	During the interview, F	R31 did not acknowledge				
		ny abuse, but stated there				
		n staff to answer her call				
		to wait for long periods of				
	time for staff assistanc	e with care including				

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<i>t</i>		ID HUMAN SERVICES			,	FOF	ED: 11/2 RM APPI	ROV	′ED
STATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	IO. 093 TE SURVE MPLETED		
ł		245379	B. WING			1	1/01/20 <sup>,</sup>	13	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE				
KENYON	SUNSET HOME			1	27 GUNDERSON BOULEVARD				
				۲	KENYON, MN 55946				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMP	X5) PLETIC ATE	N N
F 225	Continued From page	9	F	225					
	-	W and DON were p on 10/30/13 at 4:30 p.m. I LSW again stated they had							
	been unaware of the a reported by R3 until the	alleged allegation of abuse ne surveyors had brought it DON verified she had not						• ,	чи С
	reported the allegation the administrator or to become aware of R3's The LSW and DON ve initiated a thorough in of abuse reported by I	n of abuse immediately to OHFC when she had first s allegation on 10/28/13. erified that no one had vestigation of the allegation R3, such as interviewing						「対抗」がない	3 1) . 1
	after this issue was br administrative staff on were implemented to further potential abuse conducted, and the inc	and staff. It was not until ought to the attention of the 10/30/13, that interventions protect R31 and R3 from while an investigation was cident was reported to the						•	
	State agency late on 1	10/30/13.							
	by staff and had repor said nothing had been investigation the repor	rough treatment provided ted this to other staff, but of done about it. On further t of alleged allegation of nmediately reported to the nor an investigation							 22
	a score of 15 indicating cognitive impairment.	d on 8/13/13, that identified g the resident had not The quarterly MDS dated resident required extensive						•	
	stated that staff would bed rail while dressing	10/28/13 at 6:46 p.m., R6 "Roughly roll" them into the . R6 stated that the case							V N
ORM CMS-2567	(02-99) Previous Versions Obso	lete Event ID: EUPC	11	Fac	ility ID: 00145 If cont	inuation she	et Page	10 of	45

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PRINTED: 11/22/2013 FORM APPROVED OMB NO. 0938-0391

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
	ROVIDER OR SUPPLIER	245379	STF 127	REET ADDRESS, CITY, STATE, ZIP CODE GUNDERSON BOULEVARD NYON, MN 55946	11/01/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE
F 225	manager said she had rough treatment, but l	ld about it and that the case d talked to staff about the R6 stated she continued to ng rolled into the side rail.	F 225		
	10/30/13 from 8:00 ar provided by NA-E. Re large bed with side ra rolled R6 from side to	n to 8:30 a.m. Cares were 6 was observed lying in a ils in the up position. NA-E side four times, and oncerns with NA-E rolling R6		· ·	 
	was again questioned rough treatment. R6 help roll her from side down too hard using t keep R6 from rolling b have red marks on he rough. R6 stated she handling to the nurse seemed like nothing h the rough treatment of this surveyor if she co person had been roug	ne, as the sole person who			
	During additional inter 9:40 a.m., R6 again st into the side rail on nu NA-E, and R6 stated s treatment to nursing, i During an interview or LPN-A stated she did	view with R6 on 10/31/13 at ated she had been rolled merous occasions by she had reported the rough		·	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         245379       B. WING         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE	COMI	E SURVEY PLETED /01/2013	
	11.	/01/2013	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		1011/2010	
			-
127 GUNDERSON BOULEVARD			
KENYON SUNSET HOME KENYON, MN 55946			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION		(×5)	_
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE	41
F 225 Continued From page 11 F 225		··· · · ·	14 14 15 1
On 10/31/13 at 10:30 a.m. LSW stated she had			
not heard about issues with R6 complaints of			· .
rough treatment during cares. On asking what			
was the procedure for reporting an allegation of			
abuse or neglect the LSW stated the usual			
routine would have been for the nurse to notify			
the administrator and then the nursing director.			
Then she and the DON would investigate the			
incident and write a report.			
The facility's Vulnerable Adult/Abuse Prevention			
Policy revised 7/8/13, included "It is the right of			
each individual resident to be free from verbal,			
sexual, physical and mental abuse" Under		4	
Identification, the policy indicated, "The Law			• •
stipulates that all employees are considered			
mandated reports of any suspected incidents of			
maltreatment/neglect. They are to report			- 1-
immediately if: i. One has knowledge of maltreatment/neglect of a resident" Under How			
to report a suspected incident of abuse/neglect,		. 1 •	
the policy read, "Report all alleged violations and			
substantiated incidents to the administrator and in			-1
his/her absence contact the designated in charge			3
person of the building. They have the authority			
to: Intervene in any situation in order to protect			
residents The designee will electronically notify			
MDH/OHFC (Minnesota Department of			
Health/Office of Health Facility Complaints) via the Web or via phone for reporting incidents			·
immediately" Under Investigation/Reporting, the			
policy read, "When a complaint or a report of a			
suspected abuse/neglect event may have taken			
place to a resident of Kenyon Senior Living the			
following procedure will occur: i) DON will assess			
the resident's well being and safety. ii) Social			
Worker investigates situation to determine if the			
incident must be reported, and if so makes the			

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Facility ID: 00145

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PRINTED: 11/22/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245379 B. WING 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **127 GUNDERSON BOULEVARD** KENYON SUNSET HOME KENYON, MN 55946 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 225 Continued From page 12 F 225 report to via e-mail procedure to OHFC (Office of Health Facility Complaints) and sends a copy to CEP (Common Entry Point) in the county. Social Worker begins the internal investigation with DON. Administrator is notified of each step taken. Written statements will be obtained by all parties involved and the resident if possible will be interviewed." Under Protection, the policy read, "Residents, the alleged perpetrator, and other staff will be protected from harm during an investigation." Under Reporting/Response the policy read, "a.) Report all alleged violations and substantiated incidents to the OHFC and to all other agencies as required, and take all necessary corrective actions depending on the results of the investigation." During an interview on 10/30/13 at 11:15 a.m., the administrator stated her understanding of the VA policy and procedure had been for staff to notify the charge nurse then the charge nurse was responsible to protect the resident until the investigation was completed. That the the charge nurse was to contact the DON or LSW, and that the LSW was to file the report and contact the administrator. The administrator stated the reporting directions were available at the nursing station for all staff to use. The adminstrator verified she was not aware that she had to be immediately notified regarding allegations of abuse. The facility developed a plan for removal of the IJ that included: a re-education program for all employees to read the policy and procedures titled Complaint Resolution Policy and Procedure and Complaint/Grievance Report; each department manager was to educate all employees in their department starting

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PRINTED: 11/22/2013

	MENT OF HEALTH AN				PRINTED: 11/22/2013 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1		245379	B. WING		11/01/2013
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
KENYON	SUNSET HOME			27 GUNDERSON BOULEVARD	
		ATEMENT OF DEFICIENCIES		ENYON, MN 55946 PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	immediately with the s the managers were di employees; education include that the emplo acknowledged an und Implementation of this of policies and intervie jeopardy was removed however, noncomplian scope and severity lev a pattern on the scope nursing home determi which indicated no act more than minimal ha jeopardy. 483.13(c) DEVELOP/I ABUSE/NEGLECT, E The facility must deve policies and procedure mistreatment, neglect, and misappropriation of This REQUIREMENT by: Based on interview ar failed to implement the which indicated allega	staff currently working then rected to call all other was to be documented to oyee was contacted, and lerstanding of the policies. a plan was verified by review ew of staff. The immediate d on 10/31/13 at 4:30 p.m. nce remained at the lower vel of an F (corresponds to e and severity grid used by nation of compliance), tual harm with potential for rm that is not immediate MPLMENT TC POLICIES lop and implement written es that prohibit and abuse of residents of resident property. is not met as evidenced and record review, the facility pir Abuse Prevention Policy tions of abuse were to be	F 225	<b>F 226</b> Kenyon Sunset Home strives to ensure that each resident's allegation of abuse, neglect, mistreatment or misappropriati of their property is reported immediately to facility Administrator and person in cha according to the Vulnerable Adu policy and procedures the prohi	ırge Ilt
	investigation, and faile to protect residents inv R31, R6) who were rev	gency, failed to initiate an d to implement measures volved 3 of 3 residents (R3, viewed for allegations of ad the potential to affect all n the facility who were		mistreatment, neglect, and abus of residents and misappropriation of resident property.	

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/22/2013 FORM APPROVED

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		245379	B, WING			11/	01/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
	SUNSET HOME			12	27 GUNDERSON BOULEVARD		
<b>NEWTON</b>				K	ENYON, MN 55946		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETI DATE
F 226	Continued From pa	ace 14	F	226	1) R3 and R6 comprehensive		2.19
	implement their pol				assessment and care plan hav	e	
	inspionent alon po				been reviewed regarding abus		
	Findings include:				• •		
					neglect allegations. R31 has b		
		rable Adult/Abuse Prevention 13, included "It is the right of			discharged to home. Correctiv		-
		ident to be free from verbal,			action was put in place on Oct	ober	
		d mental abuse" Under			30, 2013. Kenyon Sunset Hom	e	
		olicy indicated, "The Law			policy requires that all alleged		
		mployees are considered of any suspected incidents of			violations involving resident		
		ect. They are to report			mistreatment, neglect, and ab		
	immediately if: i. Or	ne has knowledge of				-	
	-	ect of a resident" Under How			injuries of unknown source an	d	
		ed incident of abuse/neglect, eport all alleged violations and			misappropriation of property	be 1)	
		ents to the administrator and in			reported immediately to the		
		ntact the designated in charge			administrator, person in charg	e and	:
		ng. They have the authority			appropriate state agencies and		 1.
		situation in order to protect signee will electronically notify				-	·
		esota Department of			thoroughly investigated withir		
	Health/Office of He	alth Facility Complaints) via			days with the investigative res	ults	
		ne for reporting incidents			reported to the administrative	e staff	
		ler Investigation/Reporting, the a complaint or a report of a			and state officials as required.	lf the	
		eglect event may have taken			alleged violation is verified,		
		of Kenyon Senior Living the			appropriate corrective action	will	
		will occur: i) DON will assess					
		being and safety. ii) Social s situation to determine if the			be taken. The facility interven		
		ported, and if so makes the			prevent further potential abus		
	report to via e-mail	procedure to OHFC (Office of			while the investigation is in pr	ocess	
		plaints) and sends a copy to			and ensures that residents are	safe.	
		ry Point) in the county. Social					
		nternal investigation with r is notified of each step					
		ments will be obtained by all					
		the resident if possible will		•			

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			(X2) MUUT		CONSTRUCTION	1	10. 0938-039 TE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					MPLETED
		245379	B. WING			1	1/01/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
KENYON	SUNSET HOME				7 GUNDERSON BOULEVARD ENYON, MN 55946		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From page	15	F 2	226	2) All Kenyon Sunset Home		
	be interviewed." Unde	r Protection, the policy			residents residing in the facility	will	
		alleged perpetrator, and			be updated on Vulnerable Adul	t	
		ected from harm during an Reporting/Response the			policy and procedures. Residen	ts	
	policy read, "a.) Repo	rt all alleged violations and			will also be updated on how to		1
	substantiated incident other agencies as req	s to the OHFC and to all			report and who to report to and	b	
		actions depending on the			types of abuse (example neglec	t,	
	results of the investigation."			abuse, mistreatment, etc.).		-	
		n 10/28/13 at 2:54 p.m. R3 was asked whether or			3) Kenyon Sunset Home staff ha	is	
		e in the facility had been			been re-educated on Vulnerable	e	
		diately responded, "Yes" to Inther interview with R3 it			Adult policy, procedures and ho	w	
	was learned that R3 h	ad overheard a			and who to immediately report	to	
	next door to her. R3 w	a NA-E and R31 who lived rent on to say that NA-E told puse on and if she didn't,			when an allegation of abuse occ	curs.	
	the staff would come b	back and GET IT ON FOR			4) To ensure all employees'		
		eatening tone of voice. R3 NA-E call R31 "lazy." NA-E			understanding, knowledge and		,
		for R31 and went into R3's			compliance with these policies,		, . , . ,
		stated that NA-E "was at			Department Managers will perfe	orm	
		nad entered her bedroom arcastic and threatening			on a weekly basis for a six mont	h	
	tone, "This is the third	time I have been in here!"			duration and thereafter quarter	ly as	
		de that comment after R3 /ashcloths since she had			needed review and questioning	•	
	used her last one. R3				policies and procedures.		
		I't asked NA-E to help wash			Completion of mandated yearly	in-	
		I was upset by the way she I didn't mention my back.			services will be scheduled on a		
	She [NA-E] was so an	gry and she [NA-E] went			monthly basis for all employees	. All	
	-	don't know why she was so had spoken to licensed			in-services will include a discuss		
	practical nurse (LPN)-	A about her concerns on			and review of these policies.		
	10/26/13 but nothing h	ad been done. R3 then			and retrett of these ponoies.		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING			ATE SURVEY OMPLETED		
		245379	B. WING			44040040		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				11/01/2013
				27 GUNDERSON BOULEVARD		x		
KENYON	SUNSET HOME			ENYON, MN 55946				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 226	stopped in to see her [reference to the direct licensed practical nurs The boss [reference to and talked to me and and heard the story. I but I didn't like the act hard to dress faster, b thing and elastic stock that because of the wa had tried to dress fast	today and added, "They tor of nursing (DON) and se (LPN)-B] are on it today. o DON] came down here my daughter (F-A) was here didn't like to be a tattle tale ion she [NA-E] took. I tried ut I can't put on my arm ings myself." R3 indicated ay NA-E was acting, she	F 226	5) Completion date: <del>Janu</del> <del>2014:</del>	<del>ary 14</del> ,	Deceme 11, 2013 √P 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		
	that R3 had been adm 9/25/13, with diagnose degeneration (blindnes depression. An admiss (MDS) assessment da cognitive status as ale also indicated R3 requ activities of daily living extensive assistance w needs. R3's temporary on admission and user care plan is completed dated 9/25/13, identifie including limited mobili degeneration (blindness macular degeneration,	es which included: macular es), chronic pain, and sion Minimum Data Set ted 10/1/13, identified R3's rt and oriented. The MDS ired limited assistance with skills (ADLs), but required vith dressing and toileting care plan (one developed d until the comprehensive on day 21 after admission) d problems for R3 ty related to macular s), and falls related to and potential for			,			
	2:35 p.m., the DON ver 10/28/13, R3's family (I facility to visit and wher	ne DON on 10/30/13 at ified that on Monday F-A) had come to the n R3 told F-A what had 10/26/13 about the way						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		E SURVEY PLETED
		245379	B. WING		11/	01/2013
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			12	7 GUNDERSON BOULEVARD		
KENYON	SUNSET HOME		К	ENYON, MN 55946		• .
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 226	Continued From pa	ge 17 to LPN-B who was on duty	F 226			
	and began to inform happened on the pr					
	incident, LPN-B hac nursing (DON) to lis	I summoned the director of ten in about the incident at on the DON arrived, R3 and				
	F-A had described t NA-E that had occu	he allegation of abuse by rred on Saturday 10/26/13. had told her that she had				
	overheard an angry and NA-E. R3 had	conversation between R31 told her she felt NA-E was				i.e P
	when she had appro The DON stated that	or R31, and was still angry bached R3 to provide care. t R3 kept repeating that NA-E				• • • •
	curtain in R3's room spoken with NA-E y	NA-E had torn the privacy . The DON stated she had esterday (10/29/13) after				· ·
	informed NA-E her k and belittling to R31	and her family, and had behavior had been tormenting and R3. The DON confirmed				
	reported by R3 nor h interview with NA-E.	ented the alleged abuse had she documented the The DON verified that				-
	the administrator or allegations. In addit	-B had immediately informed the State agency about the ion, the DON verified there				
	R3 and R31 from po NA-E, and that NA-E	ntions put in place to protect tential ongoing abuse by E had been allowed to				
	two residents and ot verified that she was	-supervised, caring for these hers in the facility. The DON s new to her position at the				
	criteria for reporting.	felt R3's allegation met the				
	licensed social work	on 10/30/13 at 1:35 p.m., the er (LSW) stated she was ed abuse R3 had reported to				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES			(X2) MULTIPLE CONSTRUCTION		OMB NO. 0938-03	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245379	B. WING		11/01/2013	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP C				
KENYON SUNSET HOME			1	27 GUNDERSON BOULEVARD	· · ·	
KENTON			ĸ	KENYON, MN 55946		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 226	O antinua di Energia and	- 40	F 000			
F 220	Continued From page		F 226			
		e DON. After interviewing				
		ent to speak to the DON. At				2)
		pproached the surveyor and addressed the situation."				
	1	re was no documented				
	-	incident, nor documentation				
	to indicate how the DON had addressed the situation. The LSW stated she had been aware					
	of NA-E having had issues with how she speaks to the residents in the past, and stated that NA-E					
		vious warnings in the past				
	related to rough and r					
	residents. The LSW a					
		aining regarding issues				
	-	nity, and confidentiality, and				
	that this training occur					
		the last annual training had				
	occurred on 3/20/13, a	-				
	attended.					
						-
	On 10/30/2013 at 4 p.	m., F-A was called by the				
	•	ned regarding the alleged				
		ed by R3 that occurred on				1.12
		-A stated when R3 had told				
		ng (10/28/13) about the				
		rred on Saturday, she (F-A)				
	had immediately calle					
		e matter. F-A stated when				
	LPN-B was informed of	of the incident that had				
		, LPN-B had asked the				
		-A's concern with how R3		,		
		I on Saturday. F-A went on				
		ad made the comment that				
		of it." F-A said she had				
	called the facility socia					
	10/29/13 to clarify som					
	-	her by R3. F-A stated that				
		F-A had told the social had been working hard to				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 245379 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON SUNSET HOME KENYON, MN 55946 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DAŢĘ CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 226 Continued From page 19 F 226 get R3 to trust the staff at the nursing home so R3 would ask for help versus trying to do things on her own, due the potential of R3 getting injured. In addition, F-A stated R3 had made the comment that she had been labeled as "lazy" and that the comment had really bothered R3 greatly. On 10/30/2013 at 4:30 p.m., LPN-B was interviewed in regards to the alleged abuse regarding R3 and R31. LPN-B stated she had not worked the weekend when the incident had happened, but had been called to R3's room on Monday 10/28/13 between 9:00 a.m. and 10 a.m. at which time R3 and F-A began to tell her what had happened on Saturday 10/26/13. LPN-B said that R3 reported that NA-E had told R31 that she had been "slow" and if R31 wasn't so "lazy" they could get her cares done quicker. LPN-B said R3 had reported that when NA-E had finished cares for R31 she gone in to help R3 with morning cares. LPN-B said R3 had reported when NA-E walked into R3's room, R3 felt NA-E appeared upset and had a negative attitude toward her, and said R3 reported that NA-E had made the comment, "If you weren't all [reference to residents] so lazy or slow ... " while providing care for R3. LPN-B said as R3 was telling LPN-B about the incident, LPN-B had summoned the DON so she could also be present to hear the allegations of abuse. LPN-A said the DON met with R3 and F-A, with her then and had been told about the allegation of abuse towards R31 and R3. During an interview with LPN-A on 11/1/13 at 9:15 a.m., LPN-A stated NA-E had reported on 10/26/13, following provision of care for R31 and R3, that R3 was upset and reluctant to allow her (NA-E) to provide care. LPN-A acknowledged

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245379 B. WING 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON SUNSET HOME KENYON, MN 55946 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) ż F 226 Continued From page 20 F 226 having spoken to R3 and having been made aware of the resident's concerns about how NA-E had treated R31 and herself. LPN-A verified the allegation had not been immediately reported to the DON. LSW or administrator, and LPN-A confirmed the incident had not been reported to the State agency, that LPN-A had not initiated an investigation, nor had LPN-A implemented any protective interventions for R3 or R31. LPN-A did not think R3's complaints met the criteria for reporting. j. NA-E's personnel file was reviewed. NA-E had been employed from 2008 to 2009, had taken a year off, and had been rehired in 2010. NA-E's performance evaluations dated 10/7/11 identified an action plan of, "not get frustrated when things are busy" and the evaluation dated 11/20/12 included, "Stay out of the 'drama' keeping professional." NA-E's personnel record also included a documented incident dated 9/21/11, where two residents had complained of rough and rude treatment. The incident documentation indicated NA-E had stated, "We are short staffed so hurry up." NA-E had been verbally counseled to be respectful and considerate of residents. A corrective action report dated 2/1/12, indicated NA-E had not provided the necessary personal cares to a resident so that the resident could be ready at 1:00 p.m. to go to an appointment. The action plan directed NA-E to apologize to the family and pay attention to resident needs. The corrective action reports did not indicate NA-E had received any additional training on resident rights, time management, or communication skills. On 10/31/13 at 10:40 a.m., the administrator verified that no additional concerns with the way NA-E treated residents had been

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identified.

Event ID: EUPC11

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	- CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		245379	B. WING		11/01/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KENYON	SUNSET HOME			127 GUNDERSON BOULEVARD	
	/			KENYON, MN 55946	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET
F 226	Continued From page	921	F 22	6	
	the resident as having	tatus) of 15. The MDS also required extensive			
	During the interview, having experienced a weren't always enoug	÷			
	The administrator and been unaware of the a reported by R3 until th to their attention. The reported the allegation the administrator or to become aware of R3's The LSW and DON ve	p on 10/30/13 at 4:30 p.m. I LSW again stated they had alleged allegation of abuse he surveyors had brought it b DON verified she had not n of abuse immediately to b OHFC when she had first is allegation on 10/28/13. erified that no one had		· · ·	
	of abuse reported by I R31, other residents, a after this issue was br administrative staff on were implemented to further potential abuse	vestigation of the allegation R3, such as interviewing and staff. It was not until ought to the attention of the 10/30/13, that interventions protect R31 and R3 from a while an investigation was cident was reported to the 10/30/13.			
	by staff and had report	rough treatment provided ted this to other staff, but done about it. On further t of alleged allegation of			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		DATE SURVEY
IND PLAN U	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C	COMPLETED
		245379	B. WING			11/01/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
KENYON	SUNSET HOME			127 GUNDERSON BOULEVARD KENYON, MN 55946		•
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	I	PROVIDER'S PLAN OF 0	OPPECTION	(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETI
F 226	Continued From pag	ae 22	F 226			
		immediately reported to the	1 220			
		C nor an investigation				
	Record review indica					
		ted on 8/13/13, that identified ing the resident had not				
		t. The quarterly MDS dated				
		e resident required extensive				
	assistance from staf	f with all ADLs.				
	During an interview	on 10/28/13 at 6:46 p.m., R6				
		Id "Roughly roll" them into the		,		
		ng. R6 stated that the case				
		old about it and that the case				
	-	ad talked to staff about the R6 stated she continued to				
		ing rolled into the side rail.				
		ring morning cares on im to 8:30 a.m. Cares were				
		R6 was observed lying in a				:-
		ails in the up position. NA-E				
1		o side four times, and				
	roughly into the rails	oncerns with NA-E rolling R6				
	roughly into the fails					
		on 10/30/13 at 4:55 p.m. R6				
		d about her concerns about				
1		explained that staff would e to side, and then press				
		the sides of their hands to				
	keep R6 from rolling	back. R6 stated she would				
		er hands from staff being too				
		had reported this rough "more than once," and it				
		had been done about it as				
		continued. R6 was asked by				
		ould identify which staff				

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY
	245379	B. WING			1/01/2013
			STREET ADDRESS, CITY, STATE, ZIP C 127 GUNDERSON BOULEVARD KENYON, MN 55946	ODE	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
person had been roug identified NA-E by nar had roughly handled I During additional inter 9:40 a.m., R6 again s into the side rail on nu NA-E, and R6 stated treatment to nursing, During an interview of LPN-D stated she did told about the rough to R6.	gh with her, and R6 me, as the sole person who her. rview with R6 on 10/31/13 at tated she had been rolled umerous occasions by she had reported the rough including LPN-D. n 10/31/13 at 9:45 a.m. not remember having been reatment experienced by	F 22	6		
not heard about issue rough treatment durin was the procedure for abuse or neglect the I routine would have be the administrator and Then she and the DO	s with R6 complaints of g cares. On asking what reporting an allegation of _SW stated the usual een for the nurse to notify then the nursing director. N would investigate the				
administrator stated h policy and procedure l the charge nurse then responsible to protect investigation was com nurse was to contact t the LSW was to file th administrator. The ad reporting directions we station for all staff to u verified she was not ar immediately notified re	er understanding of the VA had been for staff to notify the charge nurse was the resident until the pleted. That the the charge he DON or LSW, and that e report and contact the ministrator stated the ere available at the nursing se. The administrator ware that she had to be				
	(EACH DEFICIENC REGULATORY OR I REGULATORY OR I Continued From page person had been roug identified NA-E by nat had roughly handled I During additional inter 9:40 a.m., R6 again s into the side rail on nu NA-E, and R6 stated treatment to nursing, I During an interview of LPN-D stated she did told about the rough the R6. On 10/31/13 at 10:30 not heard about issue rough treatment durin was the procedure for abuse or neglect the I routine would have be the administrator and Then she and the DO incident and write a re During an interview or administrator stated h policy and procedure I the charge nurse then responsible to protect investigation was com nurse was to contact t the LSW was to file th administrator. The ad reporting directions we station for all staff to u verified she was not a	F CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 23 person had been rough with her, and R6 identified NA-E by name, as the sole person who had roughly handled her.         During additional interview with R6 on 10/31/13 at 9:40 a.m., R6 again stated she had been rolled into the side rail on numerous occasions by NA-E, and R6 stated she had reported the rough treatment to nursing, including LPN-D.         During an interview on 10/31/13 at 9:45 a.m. LPN-D stated she did not remember having been told about the rough treatment experienced by R6.         On 10/31/13 at 10:30 a.m. LSW stated she had not heard about issues with R6 complaints of rough treatment during cares. On asking what was the procedure for reporting an allegation of abuse or neglect the LSW stated the usual routine would have been for the nurse to notify the administrator and then the nursing director. Then she and the DON would investigate the incident and write a report.         During an interview on 10/30/13 at 11:15 a.m., the administrator stated her understanding of the VA policy and procedure had been for staff to notify the charge nurse then the charge nurse was responsible to protect the resident until the investigation was completed. That the the charge nurse was to contact the DON or LSW, and that the LSW was to file the report and contact the administrator. The administrator verified she was	F CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING         245379       B. WING         ROVIDER OR SUPPLIER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 23       F 22         person had been rough with her, and R6 identified NA-E by name, as the sole person who had roughly handled her.       F 22         During additional interview with R6 on 10/31/13 at 9:40 a.m., R6 again stated she had been rolled into the side rail on numerous occasions by NA-E, and R6 stated she had reported the rough treatment to nursing, including LPN-D.         During an interview on 10/31/13 at 9:45 a.m. LPN-D stated she did not remember having been told about the rough treatment experienced by R6.         On 10/31/13 at 10:30 a.m. LSW stated she had not heard about issues with R6 complaints of rough treatment during cares. 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WING       ROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP C       SUNSET HOME     IT or ounderson BOULEWARD KENYON, MN 55946       SUNMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUSTBE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D       Continued From page 23 person had been rough with her, and R6 identified NA-E by name, as the sole person who had roughly handled her.     F 226       During additional interview with R6 on 10/31/13 at 9:40 a.m., R8 again stated she had been rolled into the side rail on numerous occasions by NA-E, and R6 stated she had reported the rough treatment to nursing, including LPN-D.     F       During an interview on 10/31/13 at 9:45 a.m. LPN-D stated she did not remember having been told about the rough treatment experienced by R6.     N       On 10/31/13 at 10:30 a.m. LSW stated she had not heard about issues with R6 complaints of rough treatment during cares. On asking what was the procedure for reporting an allegation of abuse or neglect the LSW stated the usual routine would have been for the nurse to notify the administrator stated her understanding of the VA policy and procedure had been for staff to notify the charge nurse was to contact the DON or LSW, and that the LSW was to file the report and contact the administrator. The administrator stated the ruse was to contact the DON or LSW, and that the LSW was to file the report and contact the administrator. The administrator stated the ruse was no contact the DON or LSW, and that the LSW was to file the report and contact the administrator. The administrator stated the nursing station for all staff to use. The administrator verified she was not aware tha	CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COUNT         ROWDER OR SUPPLIER       245379       IS.WING       THEET ADDRESS.OR TON, STATE, ZIP CODE         SUNSET HOME       IST GUNDERSON BOULEVARD       IST GUNDERSON BOULEVARD       REGULATORY OR LSC IDENTIFYING INFORMATION         RECOULD FORM WITH OF DEPICIENCIES       ID       PREVIDENCY MUST REPRECEDED BY FULL       PREVIDENCY MUST REPRECEDED BY FULL       PREVIDENCY MUST REPRECEDED BY FULL         RECOULD FORM YOUR LSC IDENTIFYING INFORMATION       ID       ID       PREVIDENCY MUST REPRECEDED BY FULL       PREVIDENCY         Continued From page 23       person had been rough with her, and R6       Identified NA-E by name, as the sole person who had roughly handled her.       F 226         During additional Interview with R6 on 10/31/13 at 9:40 am, R6 baile bab had reported the rough treatment to ursing, including LPN-D.       F       F         During an interview on 10/31/13 at 9:45 a.m.       LPN-D stated she ld not remember having been told about the rough treatment of the nurse on ontify the administrator and then the nursing including LPN-D.       F         During an interview on 10/30/13 at 11:15 a.m., the administrator stated her understanding of the VA policy and procedure had been for staff to notify the daministrator stated her understanding of the VA policy and procedure had been for staff to notify the charge nurse that her charge nurse was responsible to protect the registed the investigate the incident was that ashe had to be investigated the nursing station for all staff to u

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1		245379	B. WING	1	11/01/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KENYON	SUNSET HOME			127 GUNDERSON BOULEVARD KENYON, MN 55946	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 280 SS=D	The resident has the fincompetent or otherwincapacitated under the participate in planning changes in care and the A comprehensive care within 7 days after the comprehensive assess interdisciplinary team, physician, a registered for the resident, and co disciplines as determined, to the extent pratthe resident, the reside legal representative; a and revised by a team each assessment.	NING CARE-REVISE CP right, unless adjudged vise found to be he laws of the State, to g care and treatment or rreatment. e plan must be developed e completion of the ssment; prepared by an that includes the attending d nurse with responsibility other appropriate staff in ned by the resident's needs, cticable, the participation of ent's family or the resident's and periodically reviewed n of qualified persons after is not met as evidenced and document review, the	F 28	F 000	s a veloped s after plans ts' evised
	R36) who were newly Findings include:	admitted to the facility.		procedures. 4) Random weekly visual aud	
	R3 did not have a con developed 21 days aff R3 was admitted on 9			be completed. Licensed Socia Worker will monitor for	
	which included: macul (blindness), high blood (02-99) Previous Versions Obso	d pressure, chronic pain,		compliance.	ntinuation sheet Page 25 of 45

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TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		245379	B. WING _		11/01/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON, MN 55946	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
	3. A temporary care plan provided and it address to macular degeneratic chronic pain, altered r cellulitis of left arm an related to chronic pair degeneration, and pot effects. It did not add psychosocial wellbein adult related to abuse. The admission Minimu 10/1/2013 identified th as alert and oriented. resident for activities of identified as limited as extensive assist of one and independent in ear On 10/30/2013 at 2:15 nursing (DON) was int of a comprehensive ca to the DON, R3 did no care plan; however, R care plan.	ageal reflux disease), nic renal insufficiency stage a dated 9/25/2013 was used limited mobility related ion, bowel and bladder, nutrition related to diabetes, d abscess, altered comfort n, falls related to macular tential for medications side ress vision, communication, g, activities, or vulnerable /neglect. um Data Set dated he resident's cognitive status The functional status of the of daily living (ADL) sists of one staff except for e staff for dressing, toileting ating once set up. 5 p.m., the director of terviewed regarding the lack are plan for R3. According thave a comprehensive 3 did have a temporary	F 2	280 5) Completion date: <del>Janu</del> 2014	ary 14, Decemb II, 2013 SPy
	developed after admis	mprehensive care plan sion.			
	R36 was admitted on 9	9/25/2013 with general			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/22/2013 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
-		245379	B. WING			11	/01/2013
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
KENYON	SUNSET HOME				27 GUNDERSON BOULEVARD KENYON, MN 55946		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 280	Continued From page weakness, severe cog		F	280	F 309		
	diabetes, hypertensio chronic kidney diseas chronic obstructive pu non-Alzheimer ' s den and abnormal gait. R36's care plan with of did not include interve address the triggered admission Minimum D 10/1/13 which include vision, communication (ADL)s function/rehat bladder, mood state, f oral/dental care, press psychotropic drug use specific needs/medica management. On 10/30/2013 at 12:4 worker verified the car surveyor was compute up to date the facility f Facility policy dated 3/ Admission/Readmissio and Procedure was re Forms to be completed	n (high blood pressure), e, iron deficiency anemia, ilmonary disease, aphasia, nentia, psychotic disorder, original date of 10/16/2013 entions and treatments to areas identified on the obata Set (MDS) dated d: delirium, cognition, n, activities of daily living o potential, bowel and alls, nutritional/dehydration, sure ulcers/skin, e, physical restraints, other tions used, pain 40 p.m., the licensed social re plan provided to the er generated and the most had.			<ul> <li>Kenyon Sunset Home strives to ensure that each resident receiv necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment and plan of care.</li> <li>Kenyon Sunset Home strives to ensure an effective pain management regimen and comprehensive pain assessment completed to control chronic pain for our residents.</li> <li>1) R12 comprehensive care plan and pain assessment has been reviewed and updated. Pain management has been implemented.</li> <li>2) All Kenyon Sunset Home</li> </ul>	is in	
F 309 SS=D		RE/SERVICES FOR	F3	309	residents will have their plan o f care updated to ensure services being met. Residents needs will reviewed and revised as indicate	are be	

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00145

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING NAME OF PROVIDER OR SUPPLIER 245379 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, 127 GUNDERSON KENYON SUNSET HOME STREET ADDRESS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PRO

11/01/2013 STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON, MN 55946 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 Continued From page 27 F 309 3) All nursing department staff has or maintain the highest practicable physical, been re-educated on effective pain mental, and psychosocial well-being, in management regimen and plan of accordance with the comprehensive assessment and plan of care. care. 4) Director of Nursing will routinely This REQUIREMENT is not met as evidenced monitor for compliance. by: Based on observation, interview, and record 5) Completion date: January 14, Ŀ review the facility failed to ensure an effective 2012 pain management regimen and comprehensive 2014. pain assessment completed to control chronic pain for 1 of 3 residents (R12) reviewed for pain. Findings include: R12 had not had a comprehensive pain assessment completed to determine what non-pharmacological and medication interventions would be effective to manage chronic hip pain. During an interview on 10/28/13 at 4:28 p.m. R12 pointed to left their hip and stated it hurt. On asking if they had pain medication and did it help, R12 said they had received pain pills and they helped sometimes. R12 stated, "Just sleeps most of day" to get relief of hip pain. R12 was observed on 10/28/13 from 3:45 p.m. to 5:30 p.m., 10/29/13 at 10:00 a.m. and again on 10/30/13 from 7:15 a.m. to 7:45 a.m. During these observations R12 was observed lying in bed or in the bathroom. R12 was admitted to the facility in 2012 and had diagnoses that included depressive disorder, osteoarthrosis, and a stroke. The guarterly Minimum Data Set (MDS) dated FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: EUPC11 Facility ID: 00145 If continuation sheet Page 28 of 45

(X3) DATE SURVEY

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1)		MEDICAID SERVICES	(X2) MUL	TIPLE COI	NSTRUCTION	(X3) DATI	OMB NO. 0938-039 (X3) DATE SURVEY	
	FORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COMPLETED		
		245379	B. WING	······		11	/01/2013	
NAME OF F	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE			
KENYON	SUNSET HOME				UNDERSON BOULEVARD YON, MN 55946		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 309	8/6/13 indicated a BIN status) score of 14 to no cognitive impairme had constant pain rate 10 with 10 as worst pa pain (PRN) medication change from the 5/7/1 had not received PRN 8/6/13 MDS also ident extensive assist with b toileting and otherwise R12 used a walker to The Resident Pain Inte identified R12 as having the left hip, had trouble pain, rated the pain at unable to identify the in past 5 days. The Resi noted R12 had no schu- This assessment had up physical, clinical, or en potentially causing R12 interventions both non- medication use to cont	AS (brief intellectual mental 15 which meant R12 had ent. The MDS identified R12 ed as a 6 on a scale of 0 to ain and received as needed ns. This has been a 3 quarterly MDS where R12 pain medications. The tified R12 as requiring bed mobility, dressing, and a was independent. Also ambulate. erview form dated 8/6/13 ng pain almost constantly in a sleeping because of the 6 on a scale of 10, but was intensity of the pain over the ident Pain Interview also eduled pain medications. not identified potential vironmental risk factors 2's pain to determine what -pharmacological and rol pain.	F	309				
	and 10/14/13 identified	l not assessed the potential n or what nd pain medication						
	R12 ' s care plan dated problem of pain manag pain in left hip. The ap administer scheduled/F (although R12 had no s medications at this time	ement including chronic proaches included PRN pain medications scheduled pain					- - - -	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00145

If continuation sheet Page 29 of 45\*

1		D HUMAN SERVICES			PRINTED: 11/22/201 FORM APPROVE	ΞĎ
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	21
T		245379	B. WING		11/01/2013	
NAME OF P	ROVIDER OR SUPPLIER	· ·	s	TREET ADDRESS, CITY, STATE, ZIP CODE		_
KENYON	SUNSET HOME			27 GUNDERSON BOULEVARD (ENYON, MN 55946		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		-
F 309 F 312 SS=D	monitor for effectivene encourage mobility, o measure for pain relie non-pharmacological as ice, heat, message The director of nursing 11/1/13 at 8:45 a.m. a to tell the staff when h R12 would isolate self visits or due to being ' reference to hip pain. pain medication had b On 11/1/13 at 3:45 p.r worker and RN-B indic completed a pain asse uncontrolled pain mar R26 's depression an 483.25(a)(3) ADL CAF DEPENDENT RESIDI A resident who is unal daily living receives th maintain good nutrition and oral hygiene. This REQUIREMENT by: Based on observation review, the facility faile	doctor, call light in reach, ass of pain medication, ffer non-pharmacological f (there was not specific interventions identified such a, movement, etc.) g (DON) was interviewed on nd indicated R12 was able aving pain. DON stated in their room after family Just too darn sore" in DON verified no scheduled een attempted only PRN. n. the licensed social cated they had not essment to evaluate if tagement had contributed to d excess sleep. RE PROVIDED FOR ENTS ole to carry out activities of e necessary services to n, grooming, and personal is not met as evidenced a, interview and document ed to ensure assistance with provided for 1 of 3 resident quired assistance with	F 309	F 312 Kenyon Sunset Home strives to carry out activities of daily living providing necessary services to maintain good nutrition, groom and personal and oral hygiene f all residents. 1) R6 care plan has been review and updated to ensure resident preference, which includes	g by ing, for	
	Findings include:			grooming and personal hygiene	•	~~*h

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EUPC11

Facility ID: 00145

If continuation sheet Page 30 of 45

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		MEDICAID SERVICES					<u>10. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION		TE SURVEY MPLETED
		245379	B. WING			1	1/01/2013
NAME OF P	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
KENYON	SUNSET HOME				GUNDERSON BOULEVARD		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	T	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETIC
TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)		DATE
F 312	Continued From page	e 30	F 3	12	2) All Kenyon Sunset Home		
	D6 did not receive as	ciston oc with morning			residents will have their care	-	
	R6 did not receive as personal cares.	sistance with morning			reviewed and updated per re preference, which includes	esident	•
	R6 was observed on	10/30/13 from 8:00 a.m.to			grooming and person hygien	e.	
		ng assistant (NA)-E provided 9 R6 get ready for breakfast.			Residents' needs will be revi		
	NA-E obtained a wet				and revised as indicated.	2	
	NA-E stated R6 was r	not able to use the peri wet			3) The nursing department st	aff has	
		NA-E then positioned and nt brief, rolled R6 in bed to			been re-educated on facility	an nas	
		n proceeded to put R6's . With assistance from a			protocol on grooming and pe	ersonal	
	second NA, R6 was tr	ansferred from bed to the			hygiene along with following	the	
	assisted to dress the	mechanical lift. NA-E then upper portion of R6 ' s body,			plan of care.		
		and left the room and did not wash her face, hands, or			4) Random visual audits will l	be	
	underarms.				completed. Director of Nursi	ng will	
	On 10/31/13 at 10:00				monitor for compliance.		
	soap and water. R6 t	d up in the morning with hen stated the staff doesn ' t			5) Completion date: January	<del>14</del> ,	Decem
	•	ash her body with mourning not at bed time either.			<del>2014.</del>		11,201: SP
		m Data Set dated 8/13/13					
	noted R6 required ext						
	•	ting activities of daily living ersonal cares also had no					
	cognitive impairment. 10/31/13 directed staff	R6's care plan dated f that R6 required extensive					
		ress and dependent on					
							i
		1 10/31/13 at 9:45₄a.m. ares were to be done for the that morning cares					

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245379	B. WING _		11/01/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON, MN 55946	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETI
F 312	consisted of washing and under breasts. N allow staff to do this w done. The facility provided a	a 31 face, hands, under arms, A-F stated R6 would usually when morning cares were n undated policy entitle "6. Wash resident's face,	F 3	12	
F 329 SS=D	hands and underarms During an interview or director of nursing sta	and dry well." n 10/30/13 at 4:00 p.m. the ted that morning cares g of face, under breasts and IMEN IS FREE FROM	F 3:	29 <b>F 329</b>	
	unnecessary drugs. A drug when used in exc duplicate therapy); or without adequate mon indications for its use; adverse consequence should be reduced or combinations of the re Based on a comprehe resident, the facility mu who have not used an given these drugs unle therapy is necessary to as diagnosed and doc record; and residents v drugs receive gradual behavioral intervention	s which indicate the dose discontinued; or any asons above. nsive assessment of a ust ensure that residents tipsychotic drugs are not ess antipsychotic drug o treat a specific condition umented in the clinical who use antipsychotic dose reductions, and		<ul> <li>Kenyon Sunset Home strive ensure that each resident's comprehensive assessment ensure the residents who do use antipsychotic drugs are given these drugs unless antipsychotic drug therapy i necessary.</li> <li>1) R26 plan of care has been reviewed and updated to inte effectiveness of PRN medical parameters along with follow documentation.</li> </ul>	s to will o not not s s clude ations,

		MEDICAID SERVICES			The second se	O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		'e survey Ipleted
		245379	B. WING		1 <sup>′</sup>	1/01/2013
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
ENYON	SUNSET HOME			127 GUNDERSON BOULEVARD KENYON, MN 55946		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 329	Continued From page	32	F	2) All Kenyon Sunset Ho	ome	,
				residents will have thei	r care plans	
				evaluated and updated	to include	
				PRN effectiveness rega	rding the use	
		is not met as evidenced		of psychotropic medica	tions. The	
	failed to ensure as ne	nd record review, the facility eded (PRN) pain ixiety medications were		pharmacist will review   medications.	psychotropic	
		eness for 1 of 5 residents		2) All nursing departme	nt staff has	
		necessary drugs and the		3) All nursing departme		
	facility failed to admin	ister the antianxiety d in the care plan protocol		been re-educated on pl	-	•
	for 1 of 5 residents (R			PRN usage and effective	-	
	unnecessary drugs.			psychotropic medicatio	ns, and	
	Findings include: P26	received PRN Roxanol (is		documentation.		
	a morphine medication	n used to treat moderate to an (antianxiety medication)		4) Random visual audits	will be	
		nitoring of effectiveness of		completed. Director of I	Nursing will	2, 1 <b>4</b>
	the medication.			monitor for compliance		
	every 4 hours as need	lers for Roxanol 0.5 mg led for pain and Lorazepam y as needed for anxiety.		5) Completion date: <del>Jar</del> <del>2014.</del>	<del>luary 14,</del>	Decente 11, 2013
•	and that R26 displayed disorganized thinking, consciousness. The M during the assessment	ere cognitive impairment d behaviors of inattention,				
		and listed behaviors as ter incontinence episode,				

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	S FOR MEDICARE &	MEDICAID SERVICES			<u> </u>	DMR NO. 0938-0	1391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		245379	B. WING			11/01/2013	
	ROVIDER OR SUPPLIER		12	REET ADDRESS, CITY, STATE, ZIP ( 7 Gunderson Boulevard Enyon, MN 55946	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	E DATE	
	interventions for these medications as ordered and administering Ro agitated. If no decreas minutes, then give PF The medication admin were reviewed for Aug 2013. August 's MAR Roxanol 5 times and / Roxanol 5 times and / Roxanol vas given pr out of 12 opportunities showed R26 received 19 times and the Roxa once out of 19 opport showed R26 received 8 times and the Roxan out of 8 opportunities. The nursing documen through October 29, 2 The August document to behavior and Ativar indicated given 12 tim described the behavio identify the symptoms interventions used prio Ativan and described Ativan 10 of 12 times. documentation had 10 and Ativan use even the	e behaviors were to give ed; rule out pain by offering xanol when anxious or use in behaviors in 30 RN Ativan. histration records (MAR) gust 2013 through October showed R26 received Ativan 12 times. The ior to the Ativan only twice s. In September the MAR Roxanol 5 times and Ativan anol had been given only unities. In October the MAR Roxanol 1 time and Ativan hol had been given 0 times tation for August 1, 2013 013 had been reviewed. ation had 11 entries related to use even though the MAR es. The documentation r, but did not consistently of anxiety displayed or the por to administration of the effectiveness of the	F 329	DEFICIEN	<u>cγ</u> )		
	documentation descrit interventions, and effe The October documen related to behavior and the MAR indicated the times. The documenta	bed the behavior and ctiveness of the Ativan. tation had 7 entries that d Ativan use even though medication was given 8 tion described the cological interventions used	11 50%	y ID: 00145	lf gandiau - st	on sheet Page 34 o	of 45

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	S FOR MEDICARE &				FORM APPRON <u>OMB NO. 0938-0</u> (X3) DATE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
		245379	B. WING		11/01/2013
AME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
ENYON	SUNSET HOME			27 GUNDERSON BOULEVARD ENYON, MN 55946	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 329	medication given. The director of nursing 11/1/13 at 8:40 a.m. following through with	ack of effectiveness of the g (DON) was interviewed on DON stated staff was not the PRN directions as	F 329	-	
F 353 SS=E	PRN usage.	lan or documentation the	F 353	F 353	
	provide nursing and re maintain the highest p and psychosocial well determined by resider individual plans of car The facility must provi numbers of each of th personnel on a 24-hou care to all residents in care plans: Except when waived u section, licensed nurse personnel. Except when waived u	e. de services by sufficient e following types of ur basis to provide nursing accordance with resident under paragraph (c) of this		<ul> <li>Kenyon Sunset Home strives to ensure sufficient nursing staff to provide nursing and related serv to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resic assessments and individual plan care.</li> <li>1) R1 and R32 have passed away R31 has discharged to home. R3 R6, and R23 will be assured assistance during meal times an with activities of daily living (AD needs. R6 care plan has been</li> </ul>	vices t l lent s of /. , d L)
	by:	is not met as evidenced , interview, and document d to ensure adequate		reviewed and updated to ensure resident preference, which inclu grooming and personal hygiene.	des

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/22/2013: FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED
		245379	B. WING			1	1/01/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
KENYON	SUNSET HOME				7 GUNDERSON BOULEVARD ENYON, MN 55946		· ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	the resident's assessed including but not limite of 6 residents (R32, F assessed to need assidily living (ADL) need Findings include: R31, R1 and R6 and to observed during the s from 5:35 p.m. to 6:10 residents which include were assessed to need were three nursing as room and one licensed in and out of the dining assisted any resident dished up and delivered p.m. There were two NAs a at a table to eat. R31, a different table which table where the two N, to eat. R31, R1 and F assistance to eat and while their food had be on the table. The fourt independently while R 6:00 p.m. which was 1 was placed in front of at the table and began	e resident cares based on ed need for assistance ed to eating and dining for 6 R1, R23, R6, R31 and R3) sistance with activities of ds. the other 24 residents were upper meal on 10/28/13 0 p.m. There were eight led R31, R1 and R6 who ed assistance to eat. There sistants (NA) in the dining d practical nurse (LPN) was g room and had not with eating. All meals were ed to each resident by 5:49 assisting the four residents R1 and,R6 were seated at was located next to the As were assisting residents 86 were assessed to need had been unassisted to eat een placed in front of them th resident at the table ate 31, R1 and R6 watched. At 11 minutes after the food R31, R1 and R6 NA-B sat to to help them eat. NA-B ently stand and change			<ul> <li>2) All Kenyon Sunset Home residents will have their care reviewed and updated per re preference, which includes grooming and person hygiene Residents' needs will be revie and revised as indicated. All H Sunset Home residents will b provided with assistance duri meal times.</li> <li>3) The interdisciplinary team been re-educated on facility protocol to ensure uninterrup assistance during mealtime. T nursing department staff has re-educated on facility protocol grooming and personal hygie along with following the plan care.</li> <li>4) Random visual audits will k completed. Administrator or Director of Nursing will monitor compliance.</li> </ul>	sident e. ewed Kenyon e ng has bted he been col for ne of of	
		eat a few bites of food then ent repeating this rotation nad completed eating.			5) Completion date: <del>January 1</del> <del>2014</del> :	4,	Uccembe 11, 2013 SPN

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Facility ID: 00145

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATE	EMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
1			245379	B. WING _			11/01/2013
		ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 127 GUNDERSON BOULEVARD KENYON, MN 55946	ZIP CODE	
PF	(4) ID Refix Tag	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		
F	= 353	the dining room for th	36 concerning the staffing in is meal. DON stated that ormal " staffing for the shift.	F 3	53		
		R6 lacked services wi needed.	th personal cares as				
		stated have had to wa when they turn the ca the bathroom timely. O learned that R6 had h	n 10/28/13 at 7:10 p.m. R6 it for 40 minutes to get help Il light on so they can get to On further interview it was ad bowel incontinence while tated doesn't feel good				· · · ·
		8:30 a.m. while nursin morning care. NA-E p wet washcloth, assiste then transferred R6 to	0/30/13 from 8:00 a.m. to g assistant (NA)-E provided provided peri-care with a ed R6 to get dressed, and wheelchair. However, R6 couraged R6 to wash face,				
		preferred to be washe morning but R6 stated	that doesn ' t happen very staff doesn ' t do a very				
		noted R6 had required total assist to complete which included groomi did not have any cogni plan dated 10/31/13 di	ist of one staff to dress and				•
			10/30/13 at 4:00 p.m. the				
FORM CM	MS-2567	02-99) Previous Versions Obsol	ete Event ID: EUPC	11	Facility ID: 00145	If continua	tion sheet Page 37 of 4

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 1 FORM AF DMB NO. 09	PROVE
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SUR COMPLETE	VEY
1		245379	B. WING			11/01/2	2013
NAME OF P	ROVIDER OR SUPPLIER	•••••••••••••••••••••••••••••••••••••••		STREET ADDRESS, CITY, S	STATE, ZIP CODE		
KENYON	SUNSET HOME			127 GUNDERSON BOULE KENYON, MN 55946	EVARD		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRI	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) DMPLETION DATE
F 353	director of nursing sta	a 37 Ited that morning cares g of face, under breasts and	F 3	53			
	needed.	ssistance with toileting as					:
	stated there were time 3 times to get someon they put it on two or the felt it depended on the they don 't always an	n 10/28/13 at 5:36 p.m. R31 es R31 put call light on 2 or ne to help. On asking why nree times R31 stated they e staff that were on because swer the light very quickly. he facility had a lot of "					
	hard residents " (in recares) that would take R31 had waited to have had been during the eminutes. On answerin came in my room and	ference to needing total e 2 staff to help. The longest ve the call light answered vening shift and it took 20 ng the call light the staff immediately apologized by ng staff trouble and they					
	noted 4th request. At observed sitting in the the speaker announce staff went into bathroo	n. the call light speaker					но <u>.</u> • на •
	there was an LPN in the occupational therapist The director of nursing 10/30/13 at 1:36 p.m. thought the announcer minutes, but was unsu enough staff on duty to	ne hallway and an in the adjacent room. I was interviewed on and indicated that she ment would be every 2 re. DON felt that there was o answer the call light					
	promptly for R31. 11/ (02-99) Previous Versions Obso	/13 at 10:40 a.m. the DON lete Event ID:EUPC	:11 1	Facility ID: 00145	If continuat	ion sheet Page	a 38 of 45

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	OF DEFICIENCIES OF CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	D. 0938-039 E SURVEY PLETED
		245379	B. WING		11	/01/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		/01/2013
KENYON	SUNSET HOME			127 GUNDERSON BOULEVARD KENYON, MN 55946		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 353		38 rts did not show R31's	F 353	3		
	R31 complained of be	on 10/30/13 at 5:00 p.m. ing left on the toilet for long at made R31 frustrated. ppened frequently.				
	needed related to staf	•				
	stated she felt the facil especially during the n shift had only "two NAs R3 said that she has h	ight. R3 stated the night and they are very busy". ad to wait a long time to				
	both bladder and bowe second interview on 11 stated that last evening to get into the shower.	/1/13 at 4:40 p.m., R3 she had waited 1 ½ hours R3 said that the staff told				
	bath so R3 got undress waited." R3 said she v went to look for the LPI	t in after supper to do the sed and "waited and vas tired of waiting and N. R3 stated waiting was s that kind of place where				 
	director of nursing and stated they were aware	of the short staffing		F 356		
F 356	issues, and have discus assessment and assura 483.30(e) POSTED NU INFORMATION	nce committee.	F 356	Kenyon Sunset Home strives to ensure accurate posting of the		
		e following information on		actual hours worked for nursing staff directly responsible for	g	۱ ۰

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: 00145

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 11/22/2013 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245379	B. WING		11/01/2013
	ROVIDER OR SUPPLIER SUNSET HOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 27 GUNDERSON BOULEVARD KENYON, MN 55946	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
	<ul> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and by the following catege unlicensed nursing staresident care per shift <ul> <li>Registered nurses</li> <li>Licensed practical vocational nurses (as</li> <li>Certified nurses (as</li> <li>Certified nurse as o Resident census.</li> </ul> </li> <li>The facility must post specified above on a coff each shift. Data muse o Clear and readables o In a prominent place residents and visitors.</li> <li>The facility must, upor make nurse staffing data for review at a cost no standard.</li> <li>The facility must maint staffing data for a mini required by State law,</li> <li>This REQUIREMENT by:</li> <li>Based on observation review, the facility faile actual hours worked for resider</li> </ul>	In the posted daily nurse mum of 18 months, or as whichever is greater.	F 356	<ol> <li>1) Nurse staffing information posting has been identified an revised.</li> <li>2) Staff has been re-educated facility expectations regarding daily posted nursing staff information.</li> <li>3) Random weekly visual audit be done.</li> <li>4) Administrator or designee v monitor for compliance.</li> <li>5) Completion date: January 1- 2014.</li> </ol>	on the s will vill

Event ID: EUPC11

Facility ID: 00145

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		ID HUMAN SERVICES			FOR	:D: 11/22/201: MAPPROVEI O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245379	B. WING		11	/01/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		101/2013
KENYON	SUNSET HOME			127 GUNDERSON BOULEVARD		
	0.000			KENYON, MN 55946		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 356	Continued From page	40	F 35	6		· · · ·
F 425 SS=D	10/31/13 (days of sum scheduler. The sched posted were incorrect not a LPN, had worke that the facility had no The scheduler stated had 4 nursing assistar indicated for the day s and not 22.5 hours as stated that for 10/30/1 during day for a total of staff on the evening sh versus the 22.5 hours scheduler indicated for NAs during the day an for a total NA staffing of total of 22.5 hours; and evening shift had a tota total of 22.5 hours. In a 10/26/13 did not indica hour period, but identif LPN. In addition the 1 hours for a bath aid tha 15 hours posted for ov however, only 13 NA h During an interview on director of nursing indic posted needed to reflect that the RN needed to 483.60(a),(b) PHARMA	r 10/31/13, the facility had 4 d no bath aid. This made of 30 hours, not the posted d the NA staffing for the al of 23.5 hours and not the addition, the posting of the RN coverage for the 24 ied an overnight RN as an 0/26/13 posting listed 5 at was not scheduled and ernight NA staffing ours were scheduled. 11/1/13 at 9:20 a.m. the cated the total hours ct the correct hours and be noted on the staffing. ACEUTICAL SVC - URES, RPH e routine and emergency o its residents, or obtain	F 425	<ul> <li>F 425</li> <li>Kenyon Sunset Home strives to clarify physician order discrepancies.</li> <li>1) R17 physician's orders have reviewed and clarified per phyorder along with justification necessity of change.</li> <li>2) All Kenyon Sunset Home residents' physician's orders to been reviewed and clarified per physician orders along with justification of necessity of change.</li> </ul>	e been ysician of nave er	

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Facility ID: 00145

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		re survey MPLETED
		245379	B. WING			1	1/01/2013
	PROVIDER OR SUPPLIER			127	EET ADDRESS, CITY, STATE, ZIP CODE GUNDERSON BOULEVARD NYON, MN 55946	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
	<ul> <li>§483.75(h) of this pa unlicensed personne law permits, but only supervision of a licent A facility must provide (including procedures acquiring, receiving, administering of all du the needs of each res</li> <li>The facility must emp a licensed pharmacis on all aspects of the p services in the facility</li> <li>This REQUIREMENT by: Based on interview a facility failed to clarify discrepancies for 1 of for unnecessary medi</li> <li>Findings include: R17 physician notification dated 10/14/13 and 8, medication dosage ha or justification for the The physician notes of outpatient prescriptior compared to the signe 8/15/13. Novolog 70/7 was 35 units in mornir and on 10/14 orders N</li> </ul>	rt. The facility may permit I to administer drugs if State under the general used nurse. e pharmaceutical services is that assure the accurate dispensing, and rugs and biologicals) to meet sident. bloy or obtain the services of it who provides consultation provision of pharmacy '. - is not met as evidenced and document review, the physician order 5 residents (R17) reviewed ications. - lacked reconciliation and of discrepancies for orders /15/13 orders. The ad changed yet no indication change was found. - dated 10/14/13 listed current hs and these were ed physician orders dated 30 insulin on 8/15 orders ing and 20 units in evening	F	425	<ul> <li>3) All nursing department staff been re-educated on facility protocol on transcribing physici orders and ensuring physician justification for necessity of cha</li> <li>4) Random visual audits will be completed. Director of Nursing monitor for compliance.</li> <li>5) Completion date: January 14 2014.</li> </ul>	ange. will	Recember 2013 SPH

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED, **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 245379 B. WING 11/01/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON SUNSET HOME KENYON, MN 55946 SUMMARY STATEMENT OF DEFICIENCIES ΊD PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRFFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 425 Continued From page 42 F 425 Glucagon on the 8/15/13 orders was as needed, but not listed on the 10/14/13 orders. Due to the change in the dose of insulin and no physician justification as to why the change was necessary the nurse should have contacted the physician to clarify if this is the correct dose increase or if it was done in error. The medication administration records indicated R17 was to receive Novolog 70/30 insulin 35 units in the morning and 20 units before supper. The director of nursing was interviewed on 10/30/13 at 12:50 p.m. She stated she was responsible for checking the orders from the F 520 physician and stated she had signed these on 10/14/13. She stated she had missed the fact that these were changes from the past dosage of Kenvon Sunset Home strives to insulin. maintain a quality assessment and F 520 483.75(o)(1) QAA F 520 COMMITTEE-MEMBERS/MEET assurance committee consisting of SS=F QUARTERLY/PLANS the director of nursing services; a physician designated by the facility; A facility must maintain a quality assessment and and at least 3 other members of the assurance committee consisting of the director of facility's staff. nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. 1) Quality assessment and assurance (QAA) committee will The quality assessment and assurance develop and implement plans of committee meets at least quarterly to identify issues with respect to which quality assessment action related to identified and assurance activities are necessary; and problems within the nursing develops and implements appropriate plans of action to correct identified quality deficiencies. department related to staffing and care needs. A State or the Secretary may not require

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CENTERS FOR MEDICARE & MEDICARE SCHUCES         OME NO. 0538-0391           STATEMENT OF DEFICIENCIES         (X2) MULTIPLE CONSTRUCTION         (X2) MULTIPLE CONSTRUCTION           ABUDING         245379         B. WNG         (Y2) MONDERS OF SUPPLER           KENYON SUNSET HOME         STREET ADDRESS, CITY, STATE, ZIP CODE         11/01/2013           MARE OF PROVIDER OR SUPPLER         STREET ADDRESS, CITY, STATE, ZIP CODE         12/01/2013           KENYON, SUNSET HOME         STREET ADDRESS, CITY, STATE, ZIP CODE         000000000000000000000000000000000000			ND HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391
NMME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         YEARYON SUNSET HOME       STREET ADDRESS, CITY, STATE, ZIP CODE         YEARYON SUNSET HOME       STREET ADDRESS, CITY, STATE, ZIP CODE         YEARYON SUNSET HOME       STREET ADDRESS, CITY, STATE, ZIP CODE         YEARYON SUNSET HOME       STREET ADDRESS, CITY, STATE, ZIP CODE         YEARYON, MIN 55946       FOROTOERS PLAN OF CORRECTION         RECOULDERS FLAN OF CORRECTION       IPREFIX         TAG       STREET ADDRESS, CITY, STATE, ZIP CODE         YEARYON, MIN 55946       FOROTOERS PLAN OF CORRECTION         RECOULDERS FLAN OF CORRECTION       IPREFIX         TAG       STREET ADDRESS, CITY, STATE, ZIP CODE         YEARYON, MIN 55946       FOROTOERS PLAN OF CORRECTION         RECOULDERS FLAN OF CORRECTION       IPREFIX         TAG       STREET ADDRESS, CITY, STATE, ZIP CODE         YEARYON, MIN 55946       STREET ADDRESS, CITY, STATE, ZIP CODE         RECOULDER OF CORRECTION       STREET ADDRESS, CITY, STATE, ZIP CODE         RECOULDER STATE, ZIP CODE       STREET ADDRESS, CITY, STATE, ZIP CODE         RECOULDER STATE, ZIP CODE       STREET ADDRESS, CITY, STATE, ZIP CODE         RECOULDER STATE, ZIP CODE       STREET ADDRESS, CITY, STATE, ZIP CODE         RECOULDER STATE, ZIP CODE       STREET ADDRESS, CITY, STATE, ZIP, CODE     <	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATI	E SURVEY
VEENVON SUNSET HOME         127 GUNDERSON BOULEVARD KENVON, NN 55946           (X4) D PREXX TAG         SUMMARY STREMENT OF DEFICIENCIES REQUITIONS OF CORRECTION REQUITIONS OF CORRECTION REQUITIONS INCOMESTION REQUITIONS OF CORRECTION REQUITIONS OF CORRECTION RECOVER OF COMPARING DEFICIENCY         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF CORRECTION RECOVER OF COMPARING DEFICIENCY)         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF CORRECTION RECOVER OF COMPARING DEFICIENCY)         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF CORRECTION RECOVER OF CORRECTION RECOVER OF COMPARING DEFICIENCY)         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF COMPARING DEFICIENCY)         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF CORRECTION RECOVER OF COMPARING DEFICIENCY)         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF CONSTREEMENT RECOVER OF COMPARING DEFICIENCY)         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF COMPARING DEFICIENCY)         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF CONSTREEMENT RECURSTING STATUS         COUNTERNAL (CONSTREEMENT OF CORRECTION RECOVER OF COUNTIES STATUS         COUNTERNAL (CONSTREEMENT RECURSTING STATUS         COUNTERNAL (CONSTREEMENT RECURSTING STATUS         COUNT (CONSTREEMENT RECURSTING STATUS         COUNT (CONSTREEMENT RECURSTING STATUS         COUNT (CONSTREEMENT STATUS         COUNT (CONSTREEMENT STATUS         COUNT (CONSTREEMENT STATUS         COUNT (CONSTREEMENT STATUS         COUNT (CONSTREEMENT STATUS			245379	B. WING		· · · · · · · · · · · · · · · · · · ·	11	/01/2013
KENYON SUNSET HOME         KENYON, MN 55946           (X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICEXY MUST BERECEEDE BY FULL REGULATORY OR LSC IDENTFYING INFORMATION)         ID PREFIX TAG         PREFIX PREFIX TAG         ID PREFIX PREFIX TAG         PREFIX PREFIX TAG         PREFIX PREFIX TAG         PRODUCTS PLUID BE CACH DEPROPRIATE DEFICIENCY         Commentation (CASE REFERENCED TO THE APPROPRIATE DEFICIENCY)         Commentation (CASE REFERENCED TO THE APPROPRIATE	NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		۰.
PREFIX TAG       LEACH DEFICIENCY MUST BE PRECEIBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CREAT CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       COMPLETION BATE         F 520       Continued From page 43 disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.       F 520       2) Kenyon Sunset Home staff along with the QAA committee has been re-educated on facility expectations in regards to implementing reorganization of staffing arrangements to meet the resident needs.       Image: Completion of arrangements to meet the resident needs.         This REQUIREMENT is not met as evidenced by: Based on interview the facility quality assessment and assurance committee had not developed and implemented plans of action related to an identified problem of nursing. This had the polential to affect all 27 residents in the facility.       3) Random weekly visual audits will be done which will include the reorganization of the structure of staffing arrangement.         Findings include:       The administrator and licensed social worker had been interviewed on 111/113 at 5:30 p.m. They indicated that they had been aware of the short staffing issues and had discussed it with the quality assessment and assurance committee (QA&A). The discussion included the impact of the budget and the short supply of staff applicants. The QA committee and the medical director had identified the need for better staffing eespecially with the higher acuity residents       S) Completion date: Hamuary 14, 2014-	KENYON	SUNSET HOME						:
disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview the facility quality assessment and assurance committee had not developed and implemented plans of action related to an identified problem of nursing. This had the potential to affect all 27 residents in the facility. Findings include: The administrator and licensed social worker had been interviewed on 111/1/13 at 5:30 p.m. They indicated that they had been aware of the short staffing issues and had discussed it with the quality assessment and assurance committee (QA&A). The QA committee and the medical director had identified problems of nursing applicants. The QA committee and the medical director had identified the need for better staffing especially with the higher aculty residents	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
She brought this concern to the board of directors for help.       Image: Concern to the board of directors for help.         The administrator indicated the short staffing issue had been discussed with the QA&A board for over a year, but the facility had not looked at alternatives to nursing assistants for some of the       Image: Concern to the board of directors for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistants for some of the facility had not looked at alternatives to nursing assistant at alternatives to nursing assistant at alte		disclosure of the reco except insofar as such compliance of such co requirements of this s Good faith attempts b and correct quality de a basis for sanctions. This REQUIREMENT by: Based on interview th assessment and assu developed and implen related to an identified had the potential to aff facility. Findings include: The administrator and been interviewed on 1 indicated that they had staffing issues and had quality assessment an (QA&A.) The discussi the budget and the she applicants. The QA c director had identified especially with the higl currently in the facility. she brought this conce for help. The administrator indic issue had been discus for over a year, but the	rds of such committee h disclosure is related to the ommittee with the ection. y the committee to identify ficiencies will not be used as is not met as evidenced he facility quality rance committee had not nented plans of action d problem of nursing. This fect all 27 residents in the licensed social worker had 1/1/13 at 5:30 p.m. They d been aware of the short d discussed it with the id assurance committee ion included the impact of ort supply of staff ommittee and the medical the need for better staffing her acuity residents The administrator stated ern to the board of directors	F	520	<ul> <li>with the QAA committee has be re-educated on facility expectation in regards to implementing reorganization of staffing arrangements to meet the residence needs.</li> <li>3) Random weekly visual audits be done which will include the reorganization of the structure staffing arrangement.</li> <li>4) Administrator or designee wi monitor for compliance.</li> <li>5) Completion date: January 14</li> </ul>	een tions lent will of	Accember 2013

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		ND HUMAN SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED
		245379	B. WING			11/01/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 127 GUNDERSON BOULEVARI		
KENYON	SUNSET HOME			KENYON, MN 55946	-	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT CIENCY)	(X5) COMPLETION DATE
F 520	Continued From page duties nor action plan concern.	e 44 s developed to address the	F 5	20		
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RM CMS-2567	(02-99) Previous Versions Obsol	ete Event ID: EUPC		Facility ID: 00145		on sheet Page 45 of 45

ATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 1 - Main Building 01		te survey Mpleted
		246379	B. WING		1	0/30/2013
NAME OF PR	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 27 GUNDERSON BOULEVARD		
KENYON	SUNSET HOME			ENYON, MN 55946		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
к 000 К 000		WILL SERVE AS YOUR MPLIANCE UPON THE	K 000	1		
13-11-1	DEPARTMENT'S ACC SIGNATURE AT THE PAGE OF THE CMS- USED AS VERIFICAT	CEPTANCE, YOUR BOTTOM OF THE FIRST		POC 12 13-1	3	***
DC	ONSITE REVISIT OF CONDUCTED TO VA SUBSTANTIAL COMI REGULATIONS HAS	YOUR FACILITY MAY BE				.3
r: //-/-/3 .	Minnesota Departmer Fire Marshal Division. Kenyon Sunset Home substantial complianc participation in Medica Subpart 483.70(a), Lif 2000 edition of Nation Association (NFPA) S Code (LSC), Chapter PLEASE RETURN TH CORRECTION FOR DEFICIENCIES	e with the requirements for are/Medicaid at 42 CFR, ie Safety from Fire, and the al Fire Protection tandard 101, Life Safety 19 Existing Health Care. IE PLAN OF		DEC - 5 MN DEPT. OF PUBL STATE FIRE MARSH/	IC SAFETY	
EXIT:	(K-TAGS) TO: Health Care Fire Insp State Fire Marshal Div 445 Minnesota St., Su St Paul, MN 55101-51	/ision iite 145	20			k Ter M
ORATORY		UPPLIER REPRESENTATIVE'S SIGNATUR	ie	TITLE DI DI CE	the state	(X6) DATE 1.3/5//3
r safeguar	ds provide sufficient protection	on to the patients. (See Instructions.) Ex	cept for nursing in sing homes, the ab	excused from correcting providing it is de omes, the findings stated above are disclu- bove findings and plans of correction are n approved plan of correction is requisite	elermined that osable 90 days disclosable 14	<u>, , , , , , , , , , , , , , , , , , , </u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245379	B. WING		1	0/30/2013
	Rovider or supplier Sunset Home			STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON, MN 55948		,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(XS) COMPLETIO DATE
K 000	Continued From pa By email to: Barbara.Lundberge Marian.Whitney@s	@state.mn.us and	K 000			* 
2	DEFICIENCY MUS FOLLOWING INFO	what has been, or will be, done				
ii.	3. The name and/o responsible for con	oposed, completion date. r title of the person rection and monitoring to			2	Ē
8 18 19	Kenyon Sunset Ho building was constr original building wa determined to be o with partial baseme constructed and wa II(111) construction 1968, an addition w	ence of the deficiency. me is a 1-story building. The fucted at 3 different times. The s constructed in 1958 and was f Type II (111) construction, ent. In 1966, an addition was is determined to be of Type , with a partial basement. In vas constructed and was f Type II (111) construction, with	9	2 10 10	2	
2	met the constructio buildings and the fa building. The nursing home i assisted living facili by a 2-hour fire wal	al building and the 2 additions n type allowed for existing icility was surveyed as one s separated from both an ty and The Gunderson House Is with opening protectives d, self-closing, 90-minute fire				2

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PRINTED: 11/22/2013

TATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1	CONSTRUCTION	X3) DATE SURVEY COMPLETED
		245379	B. WING		10/30/2013
	ROVIDER OR SUPPLIER		= 1	TREET ADDRESS, CITY, STATE, ZIP CODE 27 GUNDERSON BOULEVARD KENYON, MN 55946	
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETI DATE
K 000	rated door assemblie The facility is fully fire The facility has a fire corridor smoke detec	s, sprinkler as of 08/09/2013. alarm system with full tion in and spaces open to monitored for automatic fire	K 000		5 5 3
а жа к	census of 23 at time of The requirement at 43 NOT MET as evidence	2 CFR, Subpart 483.70(a) is ed by:	14 040	K 018	
K 018 SS=D	Doors protecting corre- required enclosures of hazardous areas are those constructed of re- wood, or capable of re- minutes. Doors in sp required to resist the no impediment to the are provided with a me the door closed. Duto are permitted. 19.3	hibited by CMS regulations	K 018	<ol> <li>Kenyon Sunset Home will che all corridor doors to ensure they fully close and latch into their frames. Kenyon Sunset Home w purchase necessary equipment replace and fix doors found to b deficient to ensure they are in compliance and provide safety.</li> <li>Kenyon Sunset Home complet this on December 4, 2013.</li> <li>Director of Maintenance, Day Floren, is responsible for correct and monitoring.</li> </ol>	rid

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FORM APPROVED
OMB NO. 0938-0391

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245379	1 ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 10/30/2013	
	ROVIDER OR SUPPLIER SUNSET HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 127 GUNDERSON BOULEVARD KENYON, MN 55948	*	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO	
K 018	Based on observatio facility has corridor do their frames in accord of 2000 NFPA 101, S	e 3 not met as evidenced by: in and staff interview, the bors that do not latch into dance with the requirements ections 19.3.6.3.2. The ild affect all 23 residents.	K 01	8		
	on 10/30/2013, obser	en 9:30 AM and 11:30 AM vation revealed that the (which opens into the				
K 050 SS=D	Facility Maintenance discovery. NFPA 101 LIFE SAFE Fire drills are held at varying conditions, at The staff is familiar w that drills are part of e Responsibility for plan assigned only to com qualified to exercise h conducted between 9	a was confirmed by the Director (DF) at the time of ETY CODE STANDARD unexpected times under least quarterly on each shift. ith procedures and is aware established routine. Inning and conducting drills is petent persons who are eadership. Where drills are PM and 6 AM a coded be used instead of audible	K 05	<ul> <li>K 050</li> <li>1) Kenyon Sunset Home will fire drills at unexpected time under varying conditions, a quarterly on each shift.</li> <li>2) Kenyon Sunset Home will complete the fire drills at le quarterly on each shift and varying times.</li> <li>3) Director of Maintenance Floren, is responsible for complete for complete</li></ul>	nes ( <sup>0</sup> ), <sup>1</sup> , <sup>1</sup>	
		not met as evidenced by: ation review and staff		completion, and monitorir	ng.	

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PRINTED: 11/22/2013 FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 10/30/2013 A WNG 245379 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 127 GUNDERSON BOULEVARD KENYON SUNSET HOME KENYON, MN 55946 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1 K 050 K 050 Continued From page 4 interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 23 residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 10/30/2013, the review of the fire drill documentation for the past 12 months (October 2012 to September 2013) revealed the drills for the following shifts were completed but did not sufficiently vary the times that the drills were conducted: K 071 Day: 1251, 1300, 1000 and 1303 hours Evening: 1405, 1414, 1420 and 2030 hours 1) Kenyon Sunset Home will check facility laundry chute to ensure it This deficient practice was confirmed by the automatically shuts and latches. Facility Maintenance Director (DF) at the time of discovery. K 071 NFPA 101 LIFE SAFETY CODE STANDARD K 071 Kenyon Sunset Home will SS≂E complete this by January 14, 2014. Rubbish Chutes, Incinerators and Laundry J Chutes: 3) Director of Maintenance, David (1) Any existing linen and trash chute, including Floren, is responsible for correction, pneumatic rubbish and linen systems, that opens completion, and monitoring. directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. Event ID: EUPC21

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00145

If continuation sheet Page 5 of 7;

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING <b>01</b>		(X3) DATE SURVEY COMPLETED			
		245379	B. WING		10/	30/2013	
	ROVIDER OR SUPPLIER SUNSET HOME	d	12	REET ADDRESS, CITY, STATE, ZIP'CODE 7 GUNDERSON BOULEVARD ENYON, MN 55946			
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K 071	(2) Any rubbish chute pneumatic rubbish an with automatic exting	e or linen chute, including 1d linen systems, is provided	K 071	К 147		i i	
* * * *	collection room used protected in accordan (4) Existing flue-fed in	ncinerators are sealed by fire to prevent further use.	Ĩ	1) Kenyon Sunset Home wil facility for extension cord u Extension cords have been and six-plex adaptor has be removed.	se. removed	≈ √ :. • (£ 8 ≩ · • • • • 1	
5 12 13 13	This STANDARD is in Based on observation chute that does not m Sections 19.5.4, 9.5 and deficient practice cour Finding include: On facility tour between	not met as evidenced by: ns, the facility has a laundry neet the requirements of and 8.4 and NFPA 82. This Id affect 23 residents en 9:30 AM and 11:30 AM		<ol> <li>Kenyon Sunset Home con this on October 30, 2013.</li> <li>Director of Maintenance, Floren, is responsible for co completion, and monitoring</li> </ol>	David prrection,	31-1	Ń
К 147	floor soiled linen chut corridor does automa This deficient practice Facility Maintenance discovery.	rvation revealed, that the 1st e door that is open to the tically shut and latch. e was confirmed by the Director (DF) at the time of ETY CODE STANDARD	K 147		-	а 1911 г 19 1911 г 19	
SS=D	Electrical wiring and e	equipment is in accordance nal Electrical Code. 9.1.2				. 생	

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet Page 6 of 7

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CENTERS FOR MEDICAR	H AND HUMAN SERVICES					0. 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY.		
1	245379	B. WING			10	)/30/2013		
NAME OF PROVIDER OR SUPPLIER KENYON SUNSET HOME	(25)		127	REET ADDRESS, CITY, STATE, ZIP CODE GUNDERSON BOULEVARD NYON, MN 55946		्म. 1		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ( OR LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
K 147 Continued From	page 6	к	147			5		
Based on observ facility failed to m accordance with 101 - 9.1.2, 1999 State Fire Code 6	is not met as evidenced by: vation and staff interview, the aintain electrical supply in the requirements of 2000 NFPA NFPA 70, and 2007 Minnesota 005.4 and 605.5. The deficient ect 11 out of 23 residents.							
on 10/30/2013, o	tween 9:30 AM and 11:30 AM bservation revealed, that the							
into extension cor 2. 1st floor - Diet a. desk light i b. power strip 3. Resident room extension cord	nen - rolling cooler is plugged d ary supervisor office s plugged into extension cord plugged into six-plex adaptor # 226 - nebulizer plugged into							
Facility Maintenar discovery. *TEAM COMPOS	ractices were confirmed by the nce Director (DF) at the time of ITION* .ife Safety Code Spc.	a.		×				
		n:						
Previous Versions	Obsolete Event ID; EU	PC21	Facility	/ ID; 00145	If continuation st	heet Page 7 of		

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Kenyon Senior *Living* 

Kenyon Sunset Home • Gunderson Gardens • Gunderson Suites

Certified Mail

Date: December 5, 2013

Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145

RE: Project Number S5379023

Dear State Fire Marshal Division,

Thank you for working with our facility and for the commitment of your staff to the long-term care profession. With your help we will continue to improve and to provide quality care for those in our communities who need skilled nursing services.

Enclosed is our plan of correction for the Life Safety Code Survey completed October 30, 2013 at Kenyon Sunset Home.

If you have any questions or would like me to make any additions or revisions to our plan of correction, please give me a call at my direct line 507-789-7101.

Thank you,

Chelseak Ligland

Chelsea R. Ugland Acting Administrator 127 Gunderson Blvd. Kenyon, MN 55946 <u>cugland@kenyonsunsethome.com</u> 1-507-789-7101



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7011 2000 0002 5147 5243

November 25, 2013

Ms. Chelsea Ugland, Administrator Kenyon Sunset Home 127 Gunderson Boulevard Kenyon, Minnesota 55946

RE: Project Number S5379023

Dear Ms. Ugland:

On November 1, 2013, an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

# <u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

General Information: (651) 201-5000 \* TDD/TTY: (651) 201-5797 \* Minnesota Relay Service: (800) 627-3529 \* www.health.state.mn.us For directions to any, of the MDH locations, call (651) 201-5000 \* An Equal Opportunity Employer

For directions to any of the MDH locations, call (651) 201-5000 \* An Equal Opportunity Employer

Appeal Rights - the facility rights to appeal imposed remedies;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

## **REMOVAL OF IMMEDIATE JEOPARDY**

We also verified, on , that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

## DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gary Nederhoff, Unit Supervisor Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731 Fax: (507) 206-2711

## **NO OPPORTUNITY TO CORRECT - REMEDIES**

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective November 30, 2013. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

Kenyon Sunset Home November 25, 2013 Page 3

• Civil Money Penalty for the deficiency cited at F225, effective October 26, 2013. (42 CFR 488.430 through 488.444)

• Civil Money Penalty for the deficiency cited at F226, effective November 1, 2013. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

# SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Kenyon Sunset Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 1, 2013. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

# APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

Kenyon Sunset Home November 25, 2013 Page 4

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

> Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

## PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

Kenyon Sunset Home November 25, 2013 Page 5

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

## FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 1, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Kenyon Sunset Home November 25, 2013 Page 6

Services that your provider agreement be terminated by May 1, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

### **INFORMAL DISPUTE RESOLUTION**

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Kenyon Sunset Home November 25, 2013 Page 7 Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00145	B. WING		11/01/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
	SUNSET HOME			VARD		
			N, MN 55946			
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2 000	Initial Comments		2 000			
	*****ATTEN	NTION*****				
	NH LICENSING C	ORRECTION ORDER				
	144A.10, this correct pursuant to a survey found that the deficie herein are not correct not corrected shall be with a schedule of fin the Minnesota Depar Determination of whe corrected requires correquirements of the r number and MN Rule When a rule contains	ether a violation has been				
	lack of compliance. I re-inspection with an result in the assessm	Lack of compliance upon y item of multi-part rule will nent of a fine even if the item ing the initial inspection was				
	that may result from orders provided that the Department withi	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.				
	2013, surveyors of th the above provider a orders were issued. completed, please si these orders and retu	30, 31, and November 1, his Department's staff visited nd the following licensing When corrections are gn and date, make a copy of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00145	B. WING		11/01/2013	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST			
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	Compliance Monitorir Certification Program Rochester, MN 55904	; 18 Wood Lake Drive SE,		The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule out of complian- listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction orde This column also includes the findings which are in violation of the state state after the statement, "This Rule is not as evidence by." Following the survey findings are the Suggested Method of Correction and Time period for Correct PLEASE DISREGARD THE HEADING THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. TH WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	r ce is e "To er. er. sute met ors ors ction. G OF	
2 255	Assurance Committee A nursing home must assessment and assu of the administrator, t services, the medical designated by the me three other members representing disciplin resident care. The qu assurance committee	maintain a quality urance committee consisting the director of nursing director or other physician edical director, and at least of the nursing home's staff, es directly involved in uality assessment and must identify issues with ity assurance activities are	2 255			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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2 255	Continued From page	e 2	2 255			
	appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced					
	by: Based on interview th and assurance comm implemented plans o identified problem of	ne facility quality assessment nittee had not developed and				
	social worker had be 5:30 p.m. They indic aware of the short sta discussed it with the assurance committee included the impact of supply of staff applica and the medical direct for better staffing esp residents currently in	quality assessment and e (QA&A.) The discussion of the budget and the short ants. The QA committee ctor had identified the need becially with the higher acuity the facility. The she brought this concern to				
	issue had been discu for over a year, but th alternatives to nursin	licated the short staffing ussed with the QA&A board ne facility had not looked at g assistants for some of the ns developed to address the				
	The administrator, di director and consultir and revise the facility	IOD OF CORRECTION: rector of nursing, medical ng pharmacist, could review 's system used to identify rns, develop and implement				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
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2 255	Continued From page	e 3	2 255			
	issues, educate the a changes and appoint procedures to ensure	et the identified quality appropriate personnel in any a designee to monitor the ongoing compliance. ION: Twenty One (21) days.				
2 555	MN Rule 4658.0405 S Plan of Care; Develo	Subp. 1 Comprehensive pment	2 555			
	must develop a comp each resident within s completion of the com assessment as define comprehensive plan by an interdisciplinary attending physician, a responsibility for the appropriate staff in di the resident's needs,	nprehensive resident ed in part 4658.0400. The of care must be developed y team that includes the a registered nurse with resident, and other sciplines as determined by and, to the extent participation of the resident,				
	by: Based on interview a facility failed to develo comprehensive care	It is not met as evidenced nd document review, the op a resident specific plan for 2 of 4 residents (R3, y admitted to the facility.				
	Findings include:	mprehensive care plan				
	developed 21 days at					
	R3 was admitted on 9	9/25/2013 with diagnoses				

STATE FORM

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00145	00145 B. WING			
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	SUNSET HOME		IDERSON BOULEV N, MN 55946	ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
2 555	GERD (gastro-esoph depression, and chro 3. A temporary care plan provided and it addre to macular degenerat chronic pain, altered cellulitis of left arm ar related to chronic pai degeneration, and po effects. It did not add psychosocial wellbeir adult related to abuse The admission Minim 10/1/2013 identified t as alert and oriented. resident for activities identified as limited a extensive assist of or and independent in e On 10/30/2013 at 2:1 nursing (DON) was in of a comprehensive of to the DON, R3 did n	Ilar degeneration Id pressure, chronic pain, ageal reflux disease), nic renal insufficiency stage In dated 9/25/2013 was ssed limited mobility related ion, bowel and bladder, nutrition related to diabetes, ad abscess, altered comfort n, falls related to macular tential for medications side lress vision, communication, ng, activities, or vulnerable e/neglect. um Data Set dated he resident's cognitive status The functional status of the of daily living (ADL) ssist of one staff except for te staff for dressing, toileting	2 555			
	R36 did not have a co developed after admi	omprehensive care plan ssion.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00145	B. WING		11	/01/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
KENYON	SUNSET HOME		NDERSON BOULEV N, MN 55946	/ARD		
(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 ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 555	Continued From page	e 5	2 555			
	R36 was admitted on 9/25/2013 with general weakness, severe cognitive impairment, diabetes, hypertension (high blood pressure), chronic kidney disease, iron deficiency anemia, chronic obstructive pulmonary disease, aphasia, non-Alzheimer 's dementia, psychotic disorder, and abnormal gait.					
	did not include interva address the triggered admission Minimum I 10/1/13 which include vision, communicatio (ADL)s function/reha bladder, mood state, oral/dental care, pres	e, physical restraints, other				
	worker verified the ca	40 p.m., the licensed social are plan provided to the ter generated and the most had.				
	and Procedure was r Forms to be complete	ion of the Resident Policy eviewed and noted: Under ed on admission: 1. are plan should be started lete care plan to be				
	The Director of Nursi					

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMF	SURVEY
		00145	B. WING		11/01/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KENYON	SUNSET HOME		IDERSON BOULEV I, MN 55946	/ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 555	Continued From page	9 6	2 555			
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty one				
2 800	MN Rule 4658.0510 Staffing requirements	Subp. 1 Nursing Personnel;	2 800			
	home must have on of number of qualified r registered nurses, lice nursing assistants to residents at all nurses in all buildings if more	es relief duty, weekends,				
	by: Based on observation review, the facility fail nursing staff to provid the residents assesse including but not limit of 6 residents (R32, I assessed to need ass	t is not met as evidenced a, interview, and document ed to ensure adequate e resident cares based on ed need for assistance ed to eating and dining for 6 R1, R23, R6, R31 and R3) sistance with activities of ds. This had the potential hts in the facility.				
	24 residents were obs meal on 10/28/13 from There were eight resi R1 and R6 who were assistance to eat. The assistants (NA) in the licensed practical num the dining room and h	ere were three nursing dining room and one se (LPN) was in and out of				

6899

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00145	ADDRESS, CITY, STATE		11	/01/2013
KENYON	SUNSET HOME	KENYOI	N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE
2 800	Continued From pag	e 7	2 800			
	and delivered to eac	h resident by 5:49 p.m.				
	at a table to eat. R31 a different table which table the two NAs we R31, R1 and R6 wer assistance to eat and while their food had I on the table. The four independently while 6:00 p.m. which was was placed in front of at the table and begat was observed to free chairs to help all three move to the next result until R31, R1 and R60 The director of nursin 10/28/13 at 6:30 p.m. the dining room for the this would be the "m	assisting the four residents , R1 and R6 were seated at h was located next to the ere assisting resident to eat. e assessed to need d had been unassisted to eat been placed in front of them rth resident at the table ate R31, R1 and R6 watched. At 11 minutes after the food f R31, R1 and R6 NA-B sat an to help them eat. NA-B guently stand and change the eat a few bites of food then ident repeating this rotation 6 had completed eating. mg (DON) was interviewed on . concerning the staffing in his meal. DON stated that formal " staffing for the shift.				
	stated have had to w when they turn the c the bathroom timely. learned that R6 had waiting for help. R6 about that.	on 10/28/13 at 7:10 p.m. R6 vait for 40 minutes to get help all light on so they can get to On further interview it was had bowel incontinence while stated doesn't feel good				
	8:30 a.m. while nursi morning care. NA-E wet washcloth, assis	10/30/13 from 8:00 a.m. to ng assistant (NA)-E provided provided peri-care with a ted R6 to get dressed, and o wheelchair. However, R6				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00145	B. WING		11/01/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	1	
	SUNSET HOME	127 GU	NDERSON BOULE	/ARD		
		KENYO	N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pag	e 8	2 800			
	had not washed or e hands, or underarms	ncouraged R6 to wash face,				
	preferred to be wash morning but R6 state	) a.m. R6 stated would have ed up completely in the ed that doesn ' t happen very he staff doesn ' t do a very time either.				
	noted R6 had require total assist to comple which included groor did not have any cog plan dated 10/31/13	um Data Set dated 8/13/13 ed extensive assistance to ete activities of daily living ning. MDS also read that R6 initive impairment. R6's care directed staff that R6 ssist of one staff to dress and or grooming needs.				
	director of nursing st	on 10/30/13 at 4:00 p.m. the ated that morning cares ng of face, under breasts and				
	R31 did not receive a needed.	assistance with toileting as				
	stated there were tim 3 times to get some they put it on two or they put it on two or they felt it depended on the they don 't always and R31 then added that hard residents " (in reares) that would tak	on 10/28/13 at 5:36 p.m. R31 nes R31 put call light on 2 or one to help. On asking why three times R31 stated they ne staff that were on because nswer the light very quickly. the facility had a lot of " reference to needing total the 2 staff to help. The longest ave the call light answered				
	had been during the minutes. On answer came in my room an	evening shift and it took 20 ing the call light the staff d immediately apologized by <i>v</i> ing staff trouble and they				

F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
	00145	B. WING		11	/01/2013
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	1	
	127 GUN	DERSON BOULE	/ARD		
	KENYOI	N, MN 55946			
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From page	e 9	2 800			
were reorganizing.					
10/30/13. At 12:55 p noted 4th request. A observed sitting in th the speaker annound staff went into bathro call light was turned of there was an LPN in occupational therapis The director of nursin 10/30/13 at 1:36 p.m thought the announc minutes, but was uns enough staff on duty promptly for R31. 11	o.m. the call light speaker at 12:57 p.m. R31 was e bathroom. At 12:50 p.m. bed 5th request. At 1:00 p.m. bom to check on resident and off. During this time period the hallway and an at in the adjacent room. In was interviewed on and indicated that she ement would be every 2 sure. DON felt that there was to answer the call light //1/13 at 10:40 a.m. the DON				
R31 complained of b periods of time and the second	eing left on the toilet for long hat made R31 frustrated.				
stated they felt the fa especially during the only two NAs and the she has had to wait a answered and had bo bladder and bowel. D 11/1/13 at 4:40 p.m. she had waited 1 ½ b	acility was short of staff night. The night shift had by are very busy. R3 said that a long time to have light een incontinent of both During a second interview on R3 stated that last evening nours to get into the shower.				
	(EACH DEFICIENC REGULATORY OR REGULATORY OR Continued From pag were reorganizing. R31's bathroom call 10/30/13. At 12:55 p noted 4th request. A observed sitting in th the speaker annound staff went into bathro call light was turned there was an LPN in occupational therapis The director of nursin 10/30/13 at 1:36 p.m thought the annound minutes, but was unse enough staff on duty promptly for R31. 11 said the call light rep room. R31 was interviewed R31 complained of b periods of time and t R31 stated this has f R3 voiced complaints needed related to staff During an interview of stated they felt the fa especially during the only two NAs and the she has had to wait a answered and had b bladder and bowel. D 11/1/13 at 4:40 p.m. she had waited 1 ½ I R3 said that the staff	SUMSET HOME         127 GUR KENYON           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)           Continued From page 9 were reorganizing.           R31's bathroom call light was monitored on 10/30/13. At 12:55 p.m. the call light speaker noted 4th request. At 12:57 p.m. R31 was observed sitting in the bathroom. At 12:50 p.m. the speaker announced 5th request. At 1:00 p.m. staff went into bathroom to check on resident and call light was turned off. During this time period there was an LPN in the hallway and an occupational therapist in the adjacent room.           The director of nursing was interviewed on 10/30/13 at 1:36 p.m. and indicated that she thought the announcement would be every 2 minutes, but was unsure. DON felt that there was enough staff on duty to answer the call light promptly for R31. 11/1/13 at 10:40 a.m. the DON said the call light reports did not show R31's	OVIDE         STREET ADDRESS, CITY, STATE           SUMSET HOME         127 GUNDERSON BOULEX KENYON, MN 55946           SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG           Continued From page 9         2 800           were reorganizing.         2 800           R31's bathroom call light was monitored on 10/30/13. At 12:55 p.m. the call light speaker noted 4th request. At 12:57 p.m. R31 was observed sitting in the bathroom. At 12:50 p.m. the speaker announced 5th request. At 1:00 p.m. staff went into bathroom to check on resident and call light was turned off. During this time period there was an LPN in the hallway and an occupational therapist in the adjacent room.           The director of nursing was interviewed on 10/30/13 at 1:36 p.m. and indicated that she thought the announcement would be every 2 minutes, but was unsure. DON felt that there was enough staff on duty to answer the call light promptly for R31. 11/1/13 at 10:40 a.m. the DON said the call light reports did not show R31's room.           R31 was interviewed on 10/30/13 at 5:00 p.m. R31 was interviewed on 10/28/13 at 3:02 p.m. R3 stated this has happened frequently.           R3 voiced complaints of not getting care when needed related to staffing.           During an interview on 10/28/13 at 3:02 p.m. R3 stated they felt the facility was short of staff especially during the night. The night shift had only two NAs and they are very busy. R3 said that she has had to wait a long time to have light answered and had been incontinent of both bladder and bowel. During a second interview on 11/1/13 at 4:40 p.m. R3 stated that last evening she had waited 1 ½ ho	Line         Line         Line           Rowidee or supplier         STREET ADDREss, CITY, STATE, ZP CODE           SUNSET HOME         SUMMARY STATEMENT OF DEFICIENCIES (REAH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREVIDENT (REAH CONSTRUCTION OF DEFICIENCIES (REAH CONSTRUCTION OF DEFICIENCIES)         ID PREVIDENT (REAH CONSTRUCTION OF DEFICIENCIES)           Continued From page 9         2 800         2 800           Were reorganizing.         2 800         D PREVIDENT (REAH CONSTRUCTION OF DEFICIENCIES) (REAH	ONDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZP CODE           SUNSET HOME         127 GUNDERSON BOULEVARD KENYON, MK 5596           SUNMARY STATEMENT OF DEFICIENCE REQUILATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG           SUNMARY STATEMENT OF DEFICIENCE REQUILATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG           Continued From page 9         2 800           were reorganizing.         2 800           R31's bathroom call light was monitored on 10/30/13. At 12:55 p.m. the call light speaker nocled 4th request. At 10:57 p.m. R31 was observed sitting in the bathroom. At 12:50 p.m. the speaker announced 5th request. At 10:0 p.m. staff went into bathroom to check on resident and call light was sumed off. During this time period there was an LPN in the hallway and an occupational therapist in the adjacent room.           The director of nursing was interviewed on 10/30/13 at 13:36 p.m. and indicated that she thought the announcement would be every 2 minutes, but was unsure. DON feit that there was enough staff on duty to answer the call light promptly for R31. 11/1/13 at 10:40 a.m. the DON said the call light reports did not show R31's room.           R31 was interviewed on 10/30/13 at 5:00 p.m. R31 complained of being left on the toilet for long periods of time and that made R31 frustrated. R31 stated this has happened frequently.           R3 voiced complaints of not getting care when needed related to staffing.           During an interview on 10/28/13 at 3:02 p.m. R3 stated they feit the facility was short of staff especialy during the night. The night shift had only two NAs and they are very busy. R3 said that she has hadt to kours to get

Innesota Department of I TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
	00145	B. WING		11/01/2013	
AME OF PROVIDER OR SUPPLIE		ADDRESS, CITY, STATE	, ZIP CODE		
ENYON SUNSET HOME		NDERSON BOULEV N, MN 55946	ARD		
PREFIX (EACH DEFI	ARY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE
<ul> <li>was tired of wait R3 stated waitin that kind of plac</li> <li>During an interv directors of nurs stated they were issues and have assessment and</li> <li>SUGGESTED N The director of r re-evaluate staff assistance. The administrator co staffing plan tha individualized ne The director of r review and revis nursing could de which ensured a meal times. The staff compliance</li> <li>TIME PERIOD F (21) days.</li> <li>2 830</li> <li>MN Rule 4658.0 Proper Nursing</li> <li>Subpart 1. Care receive nursing custodial care, a individual needs</li> </ul>	<ul> <li>'waited and waited." R3 said he ting and went to look for the LPN. g was so frustrating, but this is e where you wait for help.</li> <li>iew on 11/1/13 at 5:30 p.m. the ting and licensed social worker e aware of the short staffing e discussed it with the quality d assurance committee.</li> <li>METHOD OF CORRECTION: hursing and administrator could fing assignments for meal director of nursing and uld develop and implement a t ensured each resident's eeds were addressed and met. Thursing and administrator could be staffing policies. The director of evelop and implement a system appropriate supervision of resident e director of nursing could monitor e.</li> <li>FOR CORRECTION: Twenty One</li> </ul>	2 800			

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00145	B. WING		11	/01/2013
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 1	/01/2013
	SUNSET HOME		IDERSON BOULEV	ARD		
			I, MN 55946	PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 11	2 830			
		e attending physician that the in bed or the resident bed.				
	by: Based on observation review the facility fail pain management re pain assessment con	nt is not met as evidenced n, interview, and record ed to ensure an effective gimen and comprehensive npleted to control chronic nts (R12) reviewed for pain.				
	determine what non-	assessment completed to pharmacological and ons would be effective to				
	pointed to left their hi asking if they had pai R12 said they had re	on 10/28/13 at 4:28 p.m. R12 p and stated it hurt. On in medication and did it help, ceived pain pills and they t12 stated, "Just sleeps most f hip pain.				
	5:30 p.m., 10/29/13 a 10/30/13 from 7:15 a	n 10/28/13 from 3:45 p.m. to at 10:00 a.m. and again on .m. to 7:45 a.m. During t12 was observed lying in m.				
		the facility in 2012 and had led depressive disorder, stroke.				
		ım Data Set (MDS) dated MS (brief intellectual mental				

STATE FORM

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00145	B. WING		11	/01/2013
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		/01/2013
			DERSON BOULE			
KENYON	SUNSET HOME	KENYON	N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 12	2 830			
	no cognitive impairm had constant pain rat 10 with 10 as worst p pain (PRN) medicatio change from the 5/7/ had not received PRI 8/6/13 MDS also ider extensive assist with toileting and otherwis R12 used a walker to The Resident Pain In identified R12 as hav the left hip, had troub pain, rated the pain a unable to identify the past 5 days. The Re noted R12 had no sc This assessment hac physical, clinical, or e potentially causing R interventions both no medication use to con Narrative nursing not and 10/14/13 identifie	13 quarterly MDS where R12 N pain medications. The ntified R12 as requiring bed mobility, dressing, and se was independent. Also o ambulate. terview form dated 8/6/13 ring pain almost constantly in ble sleeping because of the tt 6 on a scale of 10, but was intensity of the pain over the sident Pain Interview also heduled pain medications. I not identified potential environmental risk factors 12's pain to determine what n-pharmacological and ntrol pain. es dated 8/17/13, 8/27/13 ed R12 as having left hip				
	factors causing the p non-pharmacological					
	problem of pain mana pain in left hip. The a administer scheduled (although R12 had no medications at this tin	//PRN pain medications o scheduled pain me), pain assessment				
		doctor, call light in reach, ess of pain medication,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00145	B. WING	B. WING		11/01/2013	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	I	1/01/2013	
			NDERSON BOULEV				
KENYON	SUNSET HOME	KENYO	N, MN 55946				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From page	e 13	2 830				
	measure for pain relie non-pharmacological	encourage mobility, offer non-pharmacological measure for pain relief (there was not specific non-pharmacological interventions identified such as ice, heat, message, movement, etc.)					
	11/1/13 at 8:45 a.m. a to tell the staff when I R12 would isolate se visits or due to being reference to hip pain pain medication had On 11/1/13 at 3:45 p. worker and RN-B ind completed a pain ass uncontrolled pain ma R26 ' s depression an Based on observation	essment to evaluate if nagement had contributed to nd excess sleep. n, interview and document					
	· · · · ·	led to ensure assistance with s provided for 1 of 1 resident mourning cares.					
	Findings include: R6 with morning persona	did not receive assistance al cares.					
	8:30 a.m. while nursi morning cares to help NA-E obtained a wet bathroom and provide	ed peri-care to the resident.					
	wipes independently. fastened an incontine put slacks on and the	not able to use the peri wet NA-E then positioned and ent brief, rolled R6 in bed to en proceeded to put R6's					
	second NA, R6 was t wheelchair using the	<ul> <li>With assistance from a ransferred from bed to the mechanical lift. NA-E then upper portion of R6 's body,</li> </ul>					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00145	 B. WING			/01/2013
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 1	1/01/2013
KENYON	SUNSET HOME		NDERSON BOULEV N, MN 55946	ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page return to assist R6 t underarms. On 10/31/13 at 10:00 preferred to be wash soap and water. R6 always have time to v cares and sometimes R6's quarterly Minimu noted R6 required ex assistance for comple such as bathing and cognitive impairment 10/31/13 directed sta assist of one staff to o staff for grooming new During an interview of about what morning of resident, NA-F stated consisted of washing and under breasts. N allow staff to do this v done. The facility provided a A.M. Cares that read hands and underarm During an interview of director of nursing staff	e 14 o wash her face, hands, or 0 a.m. R6 stated they ed up in the morning with then stated the staff doesn ' t wash her body with mourning s not at bed time either. um Data Set dated 8/13/13 tensive assist to total eting activities of daily living personal cares also had no . R6's care plan dated fif that R6 required extensive dress and dependent on eds. on 10/31/13 at 9:45 a.m. cares were to be done for the d that morning cares face, hands, under arms, NA-F stated R6 would usually when morning cares were an undated policy entitle , "6. Wash resident's face,	2 830	DEFICIE	INCY)	
	The director of nursin					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00145	B. WING		11/01/2013	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1	101/2013
KENYON	SUNSET HOME		NDERSON BOULEV N, MN 55946	/ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pag	e 15	2 830			
	these policies and pr nursing or designee systems to ensure or					
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty One				
21410	MN Rule 4658.0815 Tuberculosis Prograr		21410			
	Tuberculosis Preven Home. Minnesota R					
	Conditions of Wavier:					
	and Prevention 's "G Transmission of Myc Health-Care Settings Mortality Weekly Rep RR-17), and as subs infection control proc	enters for Disease Control Guidelines for Preventing the obacterium tuberculosis in s, 2005," Morbidity and bort (MMWR) 2005;54 (No. equently amended, for redures and requirements Refer to this document for of terms.				
	infection control prog personnel. Administr the establishment of (one or more individu periodic update) of a development (and per infection control plan	ve responsibility for the TB gram to appropriate ative responsibilities include an infection control team uals), completion (and written TB risk assessment, eriodic review) of a written TB , and screening of health b) for TB as discussed below.				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED	
		00145	B. WING		11	/01/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
KENYON	SUNSET HOME		NDERSON BOULE\ N, MN 55946	/ARD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FU		SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21410	Continued From page	e 16	21410				
	suspected or confirm	evaluation if a case of led TB disease is not and appropriate measures					
	the local health depa	ed transmission of M.					
	by:	nt is not met as evidenced and document review the					
	assessment accordin Disease Control (CD the transmission of T	lete a Tuberculosis (TB) risk ng to the current Centers for C) guidelines for preventing uberculosis this had the residents in the facility.					
	Findings include:						
	the facility was not fo						
	indicated she was un assessment, but will	start one as of today. The					
		ated the policy stated a TB to be completed annually.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00145	B. WING		11/01/2013	
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
		127 GU	NDERSON BOULEV	/ARD		
	SUNSET HOME	KENYO	N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21410	Continued From page	e 17	21410			
	The director of nursin Tuberculosis Risk As annually.	as at low risk. IOD OF CORRECTION: og could ensure that the sessment was completed CORRECTION: Twenty One				
21415	MN Rule 4658.0815 Tuberculosis Program	· · ·	21415			
	and as defined in Mir					
	Conditions of Waiver	r:				
	"CDC Guidelines") m screening. This scree assessment of any cu two-step tuberculin sl interferon gamma rel	HCWs (as defined in the ust receive baseline TB ening must include a written urrent TB symptoms, and a kin test (TST) or single ease assay (IGRA) for M. uantiFERON® TB Gold or TB OT ® .TB).				
	"CDC Guidelines") m screening based on t low risk - not needed potential ongoing trar	he facility 's risk level: (1) ; (2) medium risk - yearly; (3) nsmission - consult the nt of Health's TB Prevention				
	<ul> <li>HCWs with abnorm must receive follow-u</li> </ul>	nal TB screening results				

	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		00145	B. WING		11	/01/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
KENYON	SUNSET HOME		NDERSON BOULEV N, MN 55946	/ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21415	Continued From pag	e 18	21415			
	according to current the diagnosis of TB.	CDC recommendations for See www.cdc.gov/tb				
	M. tuberculosis, med	s of HCW TSTs, IGRAs for lical evaluation, and chest ust be maintained in the e.				
	consistent with TB m	ng signs or symptoms nust be evaluated by a nours. These HCWs must not etermined to be				
	by: Based on interview a	nt is not met as evidenced				
	tests (TST) were rea	re employee tuberculin skin d within 48 to 72 hours of of 9 employee (E-M, E-N, and E-S) TST forms				
	Findings include: E-M hired 8/21/13 re 8/21/13 and did not h					
	12/18/12 and had the than 72 hours after a	-				
	TST 10-/14/13 and h	/13, received step one of ad the TST read 10/18/13 rs after administration.)				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		00145	B. WING		11	/01/2013
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
ENYON	SUNSET HOME		IDERSON BOULEV I, MN 55946	ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21415	Continued From page	e 19	21415		·	
	TST 9/27/13 and did E-Q received the TST read on 2/25/13 (great administration.) E-R received the TST TST read on 10/12/12 after administration) E-S received the TST TST read on 10/8/12 administration.) The facility provided at Minnesota Department Test (Mantoux). The health care provider of days after the TB skin policies entitled Mante Employee (undated), 3/1/10), Tuberculosis (undated), Tuberculosis (undated	nt of Health The TB Skin procedure read, "Your must check your arm 2 or 3 n test." The facility's oux Health Record for TB Control Plan (dated Screening Record sis (4/19/11), and Tuberculin lated) were provided by the ese policies did not provide reading of the TST. n 10/31/13 at 10:15 a.m. the ated the Mantoux test was to hours after being given. OD OF CORRECTION: g could ensure the infection ete the Tuberculosis Skin eading for all employees he recommended 48 to 72				
	MN Rule 4658.1315 \$		1			1

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00145	B. WING		11	1/01/2013
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
KENYON	SUNSET HOME		IDERSON BOULEV N, MN 55946	ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From page	e 20	21540			
	monitor each residen unnecessary drug us home's policies and p pharmacist must repor- resident's attending p physician does not co- home's recommenda adequate justification believes the resident' adversely affected, th matter to the medical medical director is no the medical director of physician does not hav the order and if the ai- change the order, the review to the Quality (QAA) committee req the attending physician	age, based on the nursing procedures, and the ort any irregularity to the physician. If the attending pncur with the nursing tion, or does not provide				
	by: Based on interview a failed to ensure as ne medication and antia monitored for effectiv (R26) reviewed for ur facility failed to admir	nxiety medications were eness for 1 of 5 residents nnecessary drugs and the nister the antianxiety ed in the care plan protocol				
	a morphine medication severe pain) and Ativ	6 received PRN Roxanol (is on used to treat moderate to ran (antianxiety medication) onitoring of effectiveness of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00145	ADDRESS, CITY, STATE		11	/01/2013
KENYON	SUNSET HOME		N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
21540	Continued From page 21		21540			
	the medication.					
	R26 had physician orders for Roxanol 0.5 mg every 4 hours as needed for pain and Lorazepam 0.5 mg four times daily as needed for anxiety. R26 's quarterly Minimum Data Set dated 9/24/13 indicated severe cognitive impairment and that R26 displayed behaviors of inattention, disorganized thinking, and altered level of consciousness. The MDS did not indicate that during the assessment period R26 displayed any behaviors of physical or verbal aggression or wandering.					
	refusal of peri-cares a yelling out at staff and interventions for thes medications as order and administering Ro	e and listed behaviors as after incontinence episode, d other residents. The e behaviors were to give ed; rule out pain by offering oxanol when anxious or ase in behaviors in 30				
	were reviewed for Au 2013. August 's MAF Roxanol 5 times and Roxanol was given p out of 12 opportunitie showed R26 received 19 times and the Rox once out of 19 opport showed R26 received	nistration records (MAR) gust 2013 through October R showed R26 received Ativan 12 times. The rior to the Ativan only twice es. In September the MAR d Roxanol 5 times and Ativan canol had been given only tunities. In October the MAR d Roxanol 1 time and Ativan anol had been given 0 times				
		ntation for August 1, 2013 2013 had been reviewed.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00145	B. WING		11	/01/2013
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
KENYON	SUNSET HOME		N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21540	Continued From page	e 22	21540			
	The August documentation had 11 entries related to behavior and Ativan use even though the MAR indicated given 12 times. The documentation described the behavior, but did not consistently identify the symptoms of anxiety displayed or the interventions used prior to administration of Ativan and described the effectiveness of the Ativan 10 of 12 times. The September documentation had 10 entries related to behavior and Ativan use even though the MAR indicated the medication had been given 19 times. The documentation described the behavior and interventions, and effectiveness of the Ativan. The October documentation had 7 entries that related to behavior and Ativan use even though the MAR indicated the medication was given 8 times. The documentation described the behavior, non-pharmacological interventions used and effectiveness or lack of effectiveness of the medication given.					
	11/1/13 at 8:40 a.m. following through with	g (DON) was interviewed on DON stated staff was not n the PRN directions as plan or documentation the				
	The director of nursin could inservice licens medication monitoring and consultant pharm review policies to ens	OD OF CORRECTION: ag and consultant pharmacist aed staff on the need for g. The director of nursing nacist could review and sure medications were stor of nursing could monitor				
	TIME PERIOD FOR ( (21) days.	CORRECTION: Twenty One				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		00145	B. WING		11	/01/2013
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 11	/01/2013
	SUNSET HOME	127 GUN	DERSON BOULEV			
-			N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
21990	Continued From page	e 23	21990			
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults		21990			
	immediately make ar entry point. Use of a for the deaf or other s considered an oral re point may not require extent possible, the r content to identify the caregiver, the nature maltreatment, any ev maltreatment, the na reporter, the time, da incident, and any oth reporter believes mig the suspected maltre reporter may disclose in section 13.02, and section 144.335, to th comply with this subo	me and address of the te, and location of the er information that the ht be helpful in investigating atment. A mandated e not public data, as defined medical records under ne extent necessary to				
	by: Based on observatio review, the facility fai the administrator, im designated State age investigation and faile (R31, R3 and R6) rev allegations. R3 repor assistant after hearin speak harshly to a ne as R31) during morn	n, interview and document led to immediately report to mediately report to the ency, complete a thorough ed to protect 3 of 5 residents viewed for abuse/neglect ted being afraid of a nursing g the nursing assistant eighboring resident (identified ing cares. Even though this vas reported to facility staff c, the facility did not				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00145	B. WING		1	/01/2013
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	. ZIP CODE	11/01/2013	
			NDERSON BOULE			
KENYON	SUNSET HOME	KENYOI	N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
21990	Continued From page	e 24	21990			
	several more days be brought this to the fact time NA-E had been an investigation was resulted in an Immed for 1 of 5 residents (F of abuse. In addition remained at risk of po- that is not immediate potential to work unsu- in the facility. The immediate jeopa when a licensed prace made aware of an all to internally report, in designated State age Complaints-OHFC), a residents. Conseque (NA-E) continued wo several days. The ac- nursing, and licensed notified of the immed 5:20 p.m. The imme- on 10/31/13 at 4:30 p noncompliance rema severity level of an F- no actual harm with p minimal harm that is Findings include: R3 at 2:54 p.m. During th whether or not she on had been abused. R3 responded, "Yes" to t interview with R3 it w	otential harm, verbal abuse, jeopardy, as NA-E had the upervised with all residents rdy began on 10/26/13, tical nurse (LPN)-A was egation of abuse and failed vestigate, report to the ency (Office of Health Facility and protect the involved ntly, the alleged perpetrator rking with the residents for dministrator, director of a social worker (LSW) were iate jeopardy on 10/30/13 at diate jeopardy was removed o.m. however, ined at the lower scope and -a pattern, which indicated botential for more than not immediate jeopardy. was interviewed on 10/28/13 ne interview, R3 was asked r anyone else in the facility				
	R31 who lived next d	oor to her. R3 went on to say get her own blouse on and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
			A. BUILDING:			
		00145	B. WING		11	/01/2013
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	SUNSET HOME		IDERSON BOULEV I, MN 55946	/ARD		
(X4) ID	KEN SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN		(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLE DATE
21990	Continued From pag	e 25	21990			
	if she didn't, the staf	f would come back and GET				
		a loud and threatening tone of				
		l also heard NA-E call R31				
	•	mpleted cares for R31 and				
		at which time R3 stated that R3 stated NA-E had entered				
		d stated, in a sarcastic and				
		his is the third time I have				
	0	id NA-E had made that				
	comment after R3 ha					
	washcloths since she	e had used her last one. R3				
		NA-E's tone, she hadn't				
	asked NA-E to help wash her back. R3 stated, "I					
	was upset by the way she [NA-E] was talking so I					
		nck. She [NA-E] was so angry				
		t out of here storming. I don't o angry." R3 stated she had				
	-	ractical nurse (LPN)-A about				
		26/13 but nothing had been				
		d her daughter family (F)				
	member-A had stopp	bed in to see her today and				
	added, "They [refere	nce to the director of nursing				
		practical nurse (LPN)-B] are				
	,	[reference to DON] came				
		d to me and my daughter				
		neard the story. I didn't like to didn't like the action she				
		ard to dress faster, but I can't				
		and elastic stockings				
		ed that because of the way				
	•	e had tried to dress faster on				
		uld not upset NA-E when she				
	came in to help her	-				
	R3's record was revi	ewed. The record identified				
		mitted to the facility on				
	-	ses which included: macular				
		ess), chronic pain, and				
		ssion Minimum Data Set				
	(ועטס) assessment (	dated 10/1/13, identified R3's				

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
	00145	B. WING		1	1/01/2013
IAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE	I •	
	127 GUI	NDERSON BOULE	ARD		
KENYON SUNSET HOME	KENYO	N, MN 55946			
PREFIX (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21990 Continued From pa	ge 26	21990			
also indicated R3 re activities of daily liv extensive assistance needs. R3's tempor on admission and u care plan is complet dated 9/25/13, ident including limited mod degeneration (blind macular degenerati medications side eff During interview wit 2:35 p.m., the DON 10/28/13, R3's fami facility to visit and v happened on Satur she and R31 had b immediately talked and began to inform happened on the pr DON, as F-A and R incident, LPN-B had nursing (DON) to list the same time. Whe F-A had described NA-E that had occu The DON stated R3 overheard an angry and NA-E. R3 had angry when caring when she had appr The DON stated that was angry and that curtain in R3's room spoken with NA-E y having met with R3	alert and oriented. The MDS equired limited assistance with ing skills (ADLs), but required are with dressing and toileting rary care plan (one developed used until the comprehensive ted on day 21 after admission) tified problems for R3 obility related to macular ness), and falls related to on, and potential for fects. The the DON on 10/30/13 at verified that on Monday ly (F-A) had come to the when R3 told F-A what had day 10/26/13 about the way een treated, F-A had to LPN-B who was on duty in LPN-B of what had dior Saturday. According to the 3 began describing the d summoned the director of sten in about the incident at en the DON arrived, R3 and the allegation of abuse by irred on Saturday 10/26/13. B had told her that she had r conversation between R31 told her she felt NA-E was for R31, and was still angry oached R3 to provide care. at R3 kept repeating that NA-E NA-E had torn the privacy h. The DON stated she had vesterday (10/29/13) after and her family, and had behavior had been tormenting				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:			E SURVEY PLETED
		004.45	B. WING			104/0040
	ROVIDER OR SUPPLIER	00145	DDRESS, CITY, STATE,		11	/01/2013
	SUNSET HOME		IDERSON BOULEV			
		KENYOI	N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	27	21990			
	reported by R3 nor ha interview with NA-E. neither she nor LPN-H the administrator or the allegations. In addition had been no interven R3 and R31 from pote NA-E, and that NA-E. continue working un-st two residents and oth verified that she was facility, and had not fe criteria for reporting. During an interview of licensed social worke unaware of the allege LPN-A, LPN-B and the the LSW, the LSW as stated the DON had " The LSW verified their record of the alleged to indicate how the DD situation. The LSW so of NA-E having had is to the residents in the had received two prev- related to rough and r residents. The LSW as responsible for staff to related to respect, dig	supervised, caring for these ers in the facility. The DON new to her position at the elt R3's allegation met the n 10/30/13 at 1:35 p.m., the r (LSW) stated she was id abuse R3 had reported to e DON. After interviewing ent to speak to the DON. At pproached the surveyor and addressed the situation." re was no documented incident, nor documentation ON had addressed the tated she had been aware ssues with how she speaks e past, and stated that NA-E vious warnings in the past rude behavior toward				
	occurred on 3/20/13, attended.	the last annual training had and that NA-E had .m., F-A was called by the				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00145	B. WING		11	1/01/2013
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	11/01/2013	
	SUNSET HOME		DERSON BOULEV			
		KENYO	N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETI DATE
21990	Continued From page	e 28	21990			
	Saturday, 10/26/13. her on Monday morn incident that had occi- had immediately calle (LPN-B) to discuss th LPN-B was informed occurred on Saturday DON to also listen to and R31 been treater to say that the DON H they "would take care called the facility soci 10/29/13 to clarify so alleged abuse told to during that phone cal worker that the family get R3 to trust the sta R3 would ask for help on her own, due the p injured. In addition, F comment that she hat that the comment had On 10/30/2013 at 4:3 interviewed in regard regarding R3 and R3 worked the weekend happened, but had bo Monday 10/28/13 bef at which time R3 and had happened on Sa	ted by R3 that occurred on F-A stated when R3 had told ing (10/28/13) about the urred on Saturday, she (F-A) ed for the LPN on duty he matter. F-A stated when of the incident that had y, LPN-B had asked the F-A's concern with how R3 ed on Saturday. F-A went on had made the comment that e of it." F-A said she had ial worker on Tuesday me of the events of the her by R3. F-A stated that II F-A had told the social y had been working hard to aff at the nursing home so to versus trying to do things potential of R3 getting F-A stated R3 had made the id been labeled as "lazy" and d really bothered R3 greatly. B0 p.m., LPN-B was s to the alleged abuse 1. LPN-B stated she had not when the incident had een called to R3's room on tween 9:00 a.m. and 10 a.m. I F-A began to tell her what turday 10/26/13. LPN-B said NA-E had told R31 that she				
	could get her cares d had reported that whe for R31 she gone in t	if R31 wasn't so "lazy" they lone quicker. LPN-B said R3 en NA-E had finished cares o help R3 with morning 3 had reported when NA-E				
		n, R3 felt NA-E appeared ative attitude toward her, and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00145	B. WING		11	/01/2013
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		10112010
	SUNSET HOME	127 GUN	NDERSON BOULEV	ARD		
			N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 29	21990			
	<ul> <li>21990 Continued From page 29</li> <li>said R3 reported that NA-E had made the comment, "If you weren't all [reference to residents] so lazy or slow" while providing care for R3. LPN-B said as R3 was telling LPN-B about the incident, LPN-B had summoned the DON so she could also be present to hear the allegations of abuse. LPN-A said the DON met with R3 and F-A, with her then and had been told about the allegation of abuse towards R31 and R3.</li> <li>During an interview with LPN-A on 11/1/13 at 9:15 a.m., LPN-A stated NA-E had reported on 10/26/13, following provision of care for R31 and R3, that R3 was upset and reluctant to allow her (NA-E) to provide care. LPN-A acknowledged having spoken to R3 and having been made aware of the resident's concerns about how NA-E had treated R31 and herself. LPN-A verified the allegation had not been immediately reported to the DON, LSW or administrator, and LPN-A confirmed the incident had not been reported an investigation, nor had LPN-A implemented any protective interventions for R3 or R31. LPN-A did</li> </ul>					
	reporting. NA-E's personnel file been employed from	aints met the criteria for was reviewed. NA-E had 2008 to 2009, had taken a en rehired in 2010. NA-E's				
	performance evaluat an action plan of, "no	ions dated 10/7/11 identified ot get frustrated when things aluation dated 11/20/12				
	professional." NA-E' included a document where two residents	s personnel record also ed incident dated 9/21/11, had complained of rough The incident documentation				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED		
		00145	B. WING		11	/01/2013		
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE				
KENYON	SUNSET HOME		NDERSON BOULEV N, MN 55946	/ARD				
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE		
21990	Continued From page 30 so hurry up." NA-E had been verbally counseled to be respectful and considerate of residents. A corrective action report dated 2/1/12, indicated NA-E had not provided the necessary personal cares to a resident so that the resident could be ready at 1:00 p.m. to go to an appointment. The action plan directed NA-E to apologize to the family and pay attention to resident needs. The corrective action reports did not indicate NA-E had received any additional training on resident rights, time management, or communication skills. On 10/31/13 at 10:40 a.m., the administrator verified that no additional concerns with the way NA-E treated residents had been identified. An initial MDS for R31 dated 10/15/13, identified the resident as having a BIMS score (brief interview for mental status) of 15. The MDS also indicated the resident required extensive assistance with all ADLs. R31 was interviewed on 10/30/13 at 5:00 p.m. During the interview, R31 did not acknowledge having experienced any abuse, but stated there		21990					
	light, and that she ha	gh staff to answer her call d to wait for long periods of nce with care including et.						
	The administrator an been unaware of the reported by R3 until t to their attention. Th reported the allegation the administrator or t become aware of R3	SW and DON were up on 10/30/13 at 4:30 p.m. d LSW again stated they had alleged allegation of abuse he surveyors had brought it e DON verified she had not on of abuse immediately to o OHFC when she had first 's allegation on 10/28/13. verified that no one had						

	T OF DEFICIENCIES OF CORRECTION	h (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00145	B. WING		11	/01/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	2	
KENYON	SUNSET HOME		IDERSON BOULEV N, MN 55946	'ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21990	initiated a thorough ir of abuse reported by R31, other residents, after this issue was b administrative staff o were implemented to further potential abus conducted, and the ir State agency late on R6 had complaints of by staff and had repo- said nothing had beer investigation the repo- abuse had not been in administrator, OHFC completed. Record review indicat assessment conducted a score of 15 indicatif cognitive impairment 8/13/13, indicated the assistance from staff During an interview of stated that staff would bed rail while dressin manager had been to manager said she har rough treatment, but have trouble with bei R6 was observed dur 10/30/13 from 8:00 a provided by NA-E. R large bed with side ra rolled R6 from side to	hvestigation of the allegation R3, such as interviewing and staff. It was not until prought to the attention of the n 10/30/13, that interventions protect R31 and R3 from se while an investigation was neident was reported to the 10/30/13. If rough treatment provided orted this to other staff, but in done about it. On further ort of alleged allegation of immediately reported to the nor an investigation ted R6 had a BIMS ed on 8/13/13, that identified ng the resident had not . The quarterly MDS dated e resident required extensive with all ADLs. on 10/28/13 at 6:46 p.m., R6 d "Roughly roll" them into the ig. R6 stated that the case old about it and that the case old about it and that the case old about it and that the case old about it of the side rail. ring morning cares on m to 8:30 a.m. Cares were 86 was observed lying in a ails in the up position. NA-E o side four times, and oncerns with NA-E rolling R6	21990	DEFICIEN		

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY IPLETED
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		00145			11	1/01/2013
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
KENYON	SUNSET HOME		N, MN 55946	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21990	Continued From page	e 32	21990			
	was again questioned rough treatment. R6 help roll her from side down too hard using keep R6 from rolling have red marks on her rough. R6 stated she handling to the nurse seemed like nothing the rough treatment of this surveyor if she co person had been rou identified NA-E by na had roughly handled During additional inte 9:40 a.m., R6 again s into the side rail on n NA-E, and R6 stated treatment to nursing, During an interview of LPN-A stated she did told about the rough R6.	when, as the sole person who her. erview with R6 on 10/31/13 at stated she had been rolled umerous occasions by she had reported the rough				
	was the procedure for abuse or neglect the routine would have b	ng cares. On asking what r reporting an allegation of LSW stated the usual een for the nurse to notify I then the nursing director.				
		ON would investigate the				
		ble Adult/Abuse Prevention , included "It is the right of				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	00145	B. WING			/01/2013
AME OF PROVIDER OR SUPPLIER	1	ADDRESS, CITY, STATE	. ZIP CODE		/01/2013
		NDERSON BOULEV			
ENYON SUNSET HOME	KENYO	N, MN 55946			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21990 Continued From page	e 33	21990			
sexual, physical and Identification, the poli stipulates that all emp mandated reports of maltreatment/neglect immediately if: i. One maltreatment/neglect to report a suspected the policy read, "Rep substantiated inciden his/her absence cont person of the building to: Intervene in any s residents The desig MDH/OHFC (Minnes Health/Office of Healt the Web or via phone immediately" Under policy read, "When a suspected abuse/neg place to a resident of following procedure w the resident's well be Worker investigates s incident must be repor report to via e-mail pr Health Facility Comp CEP (Common Entry Worker begins the int DON. Administrator taken. Written statem parties involved and the be interviewed." Under read, "Residents, the	has knowledge of of a resident" Under How incident of abuse/neglect, ort all alleged violations and ts to the administrator and in act the designated in charge g. They have the authority ituation in order to protect gnee will electronically notify ota Department of th Facility Complaints) via e for reporting incidents r Investigation/Reporting, the complaint or a report of a glect event may have taken Kenyon Senior Living the vill occur: i) DON will assess ing and safety. ii) Social situation to determine if the orted, and if so makes the rocedure to OHFC (Office of laints) and sends a copy to Point) in the county. Social ternal investigation with is notified of each step tents will be obtained by all the resident if possible will er Protection, the policy alleged perpetrator, and tected from harm during an				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
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NAME OF P	ROVIDER OR SUPPLIER		TREET ADDRESS, CITY, STATE, ZIP CODE			1/01/2013	
			IDERSON BOULEV				
KENTON	SUNSET HOME	KENYO	N, MN 55946				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE	
21990	Continued From page	e 34	21990				
	necessary corrective results of the investig	actions depending on the gation."					
	administrator stated l policy and procedure the charge nurse the responsible to protect investigation was cor nurse was to contact the LSW was to file t administrator. The a reporting directions v station for all staff to verified she was not	on 10/30/13 at 11:15 a.m., the her understanding of the VA had been for staff to notify in the charge nurse was at the resident until the mpleted. That the the charge the DON or LSW, and that he report and contact the dministrator stated the vere available at the nursing use. The administrator aware that she had to be regarding allegations of					
	that included: a re-ec employees to read th titled Complaint Resc and Complaint/Griev department manager employees in their d immediately with the the managers were c employees; educatio include that the empl acknowledged an un Implementation of thi of policies and interv jeopardy was remove however, noncomplia scope and severity le a pattern on the scop nursing home determ which indicated no an	was to educate all					

STATEMEN	ta Department of Health T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY PLETED
		00145	B. WING		11/	/01/2013
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KENYON	SUNSET HOME		IDERSON BOULEV I, MN 55946	/ARD		
()(4) ID				PROVIDER'S PLAN O		(275)
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21990	Continued From page	35	21990			
	The administrator or or revise the facility Abu to timing of reporting maltreatment. The ac could educate staff re monitor to assure the resident maltreatmen	Iministrator of designee lated to the policy and facility reported potential t timely.				
	TIME PERIOD FOR (	CORRECTION: One (1) day.				
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults		22000			
	facility, except home personal care attenda establish and enforce prevention plan. The assessment of the ph environment, and its factors which may en and a statement of sp to minimize the risk o comply with any rules promulgated by the life (b) Each facility, ind agency and personal providers, shall devel prevention plan for ea	ant services providers, shall an ongoing written abuse plan shall contain an ysical plant, its population identifying courage or permit abuse, becific measures to be taken f abuse. The plan shall governing the plan censing agency. cluding a home health care care attendant services op an individual abuse ach vulnerable adult				
	residing there or rece The plan shall contair assessment of: (1) the abuse by other individe vulnerable adults; (2) other vulnerable adult specific measures to	iving services from them. an individualized e person's susceptibility to				

	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		[ 11	/01/2013
			NDERSON BOULEV			
KENTON		KENYOI	N, MN 55946			
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22000	Continued From pag	e 36	22000			
	adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.					
	and personal care at knows that the vulne violent crime or an ac toward others, the im- plan must detail the r minimize the risk tha reasonably be expect facility and persons of unsupervised. Unde of a vulnerable adult misconduct or physi such information from authority or through a	r this section, a facility knows 's history of criminal cal aggression if it receives n a law enforcement a medical record prepared by her health care provider, or				
	by: Based on interview a failed to implement the which indicated alleg immediately reported reported to the State investigation, and fai to protect residents in R31, R6) who were r abuse. This deficient					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
	00145	2.1/2/2		11/01/2013	
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		/01/2010
		NDERSON BOULEV			
KENYON SUNSET HOME	KENYO	N, MN 55946			
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
22000 Continued From page	ge 37	22000			
Adult/Abuse Preven included "It is the rig to be free from verb mental abuse" Un indicated, "The Law are considered man suspected incidents They are to report in knowledge of maltre resident" Under H incident of abuse/ne all alleged violations to the administrator contact the designa building. They have any situation in orde designee will electro (Minnesota Departn Facility Complaints) reporting incidents i Investigation/Repor complaint or a repor abuse/neglect even resident of Kenyon procedure will occur resident's well being investigates situatio must be reported, a via e-mail procedure Facility Complaints) (Common Entry Poi Worker begins the in DON. Administrato taken. Written state	t may have taken place to a Senior Living the following r: i) DON will assess the g and safety. ii) Social Worker n to determine if the incident nd if so makes the report to to OHFC (Office of Health and sends a copy to CEP nt) in the county. Social internal investigation with r is notified of each step ments will be obtained by all t the resident if possible will				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
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		00145	B. WING		11	/01/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
(ENYON :	SUNSET HOME		NDERSON BOULEV N, MN 55946	ARD		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
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22000	Continued From pag	e 38	22000			
	policy read, "a.) Rep	ort all alleged violations and				
	substantiated incider	nts to the OHFC and to all				
	other agencies as re	•				
	•	actions depending on the				
R3	results of the investig	gation."				
	R3 was interviewed on 10/28/13 at 2:54 p.m.					
		R3 was asked whether or				
		se in the facility had been				
th		rediately responded, "Yes" to				
	•	further interview with R3 it				
	was learned that R3					
		en a NA-E and R31 who lived				
		went on to say that NA-E told plouse on and if she didn't,				
	•	back and GET IT ON FOR				
		reatening tone of voice. R3				
		d NA-E call R31 "lazy." NA-E				
		s for R31 and went into R3's				
	room at which time F	R3 stated that NA-E "was at				
	me." R3 stated NA-E	had entered her bedroom				
		sarcastic and threatening				
		d time I have been in here!"				
		ade that comment after R3				
	•	washcloths since she had				
		3 said that because of				
		dn't asked NA-E to help wash				
		, "I was upset by the way she o I didn't mention my back.				
		angry and she [NA-E] went				
		I don't know why she was so				
		he had spoken to licensed				
		)-A about her concerns on				
		had been done. R3 then				
		family (F) member-A had				
		r today and added, "They				
		ector of nursing (DON) and				
		rse (LPN)-B] are on it today.				
		to DON] came down here				
	and talked to me and	$h m (doughtor (1^{\circ} \Lambda)) u do horo$				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00145	B. WING		11	/01/2013
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	I 11	101/2013
			IDERSON BOULEV			
KENYON	SUNSET HOME	KENYON	N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 39	22000			
	but I didn't like the ac hard to dress faster, thing and elastic stoc that because of the w had tried to dress fas would not upset NA-F her with her care. R3's record was revis that R3 had been add 9/25/13, with diagnos degeneration (blindne depression. An admis (MDS) assessment of cognitive status as al also indicated R3 rec activities of daily livin extensive assistance needs. R3's tempora on admission and us care plan is complete dated 9/25/13, identifi including limited mob degeneration (blindne macular degeneration medications side effer During interview with 2:35 p.m., the DON v 10/28/13, R3's family facility to visit and wh happened on Saturda she and R31 had bee	bility related to macular ess), and falls related to n, and potential for ects. the DON on 10/30/13 at verified that on Monday (F-A) had come to the nen R3 told F-A what had ay 10/26/13 about the way en treated, F-A had b LPN-B who was on duty				
	DON, as F-A and R3 incident, LPN-B had	or Saturday. According to the began describing the summoned the director of en in about the incident at				

Minnesota Department of Health STATE FORM

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STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00145	B. WING		1-	11/01/2013	
NAME OF PROVI	DER OR SUPPLIER		DDRESS, CITY, STATE			1/01/2013	
KENYON SUN	SET HOME	KENYO	N, MN 55946				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
22000 Co	ntinued From page	e 40	22000				
F-/ NA Th ov/ an an wh Th wa cu sp/ ha infi an sh- rep int ne the all ha R3 NA co two ve fac cri ' Du lice un LP the 1:4 sta Th	A had described th A-E that had occurr e DON stated R3 I erheard an angry of d NA-E. R3 had to gry when caring fo- ien she had approa- e DON stated that is angry and that N- rtain in R3's room. oken with NA-E ye ving met with R3 a ormed NA-E her bo- d belittling to R31 a e had not documer ported by R3 nor h- erview with NA-E. ither she nor LPN- e administrator or t egations. In additid d been no interver a and R31 from pot to-E, and that NA-E ntinue working un- poresidents and oth rified that she was cility, and had not fi- teria for reporting. ring an interview of eased social worked aware of the alleged N-A, LPN-B and the a LSW, the LSW w 40 p.m., the LSW a ted the DON had	a the DON arrived, R3 and e allegation of abuse by red on Saturday 10/26/13. had told her that she had conversation between R31 old her she felt NA-E was r R31, and was still angry ached R3 to provide care. R3 kept repeating that NA-E IA-E had torn the privacy The DON stated she had isterday (10/29/13) after and her family, and had ehavior had been tormenting and R3. The DON confirmed ned the alleged abuse ad she documented the The DON verified that B had immediately informed he State agency about the on, the DON verified there at she documented the The DON verified that B had immediately informed he State agency about the on, the DON verified there at she documented the tential ongoing abuse by had been allowed to supervised, caring for these hers in the facility. The DON new to her position at the elt R3's allegation met the an 10/30/13 at 1:35 p.m., the er (LSW) stated she was end abuse R3 had reported to be DON. After interviewing ent to speak to the DON. At approached the surveyor and "addressed the situation." are was no documented insident, and documented					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
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AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE				
ENYON S	SUNSET HOME		NDERSON BOULEV N, MN 55946	/ARD			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN C (EACH CORRECTIVE AG		(X5) COMPLE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEI		DATE	
22000	Continued From pag	je 41	22000				
	situation. The LSW	stated she had been aware					
	of NA-E having had	issues with how she speaks					
		e past, and stated that NA-E					
		evious warnings in the past					
	÷	rude behavior toward					
res rela	residents. The LSW						
		training regarding issues ignity, and confidentiality, and					
		urred at orientation and					
		d the last annual training had					
	occurred on 3/20/13	-					
	attended.						
		p.m., F-A was called by the					
		oned regarding the alleged					
		ted by R3 that occurred on					
	-	F-A stated when R3 had told					
		ning (10/28/13) about the curred on Saturday, she (F-A)					
		led for the LPN on duty					
	•	he matter. F-A stated when					
		I of the incident that had					
		y, LPN-B had asked the					
		F-A's concern with how R3					
	and R31 been treate	ed on Saturday. F-A went on					
		had made the comment that					
		e of it." F-A said she had					
	-	cial worker on Tuesday					
		ome of the events of the					
		o her by R3. F-A stated that III F-A had told the social					
	•	y had been working hard to					
		aff at the nursing home so					
	•	p versus trying to do things					
		potential of R3 getting					
		F-A stated R3 had made the					
		ad been labeled as "lazy" and					
	that the comment ha	d really bothered R3 greatly.					
	On 10/30/2013 at 4:	30 p.m., LPN-B was					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
KENYON	SUNSET HOME		NDERSON BOULEV N, MN 55946	/ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
22000	Continued From pag	e 42	22000			
	regarding R3 and R3 worked the weekend happened, but had b Monday 10/28/13 be at which time R3 and had happened on Sa that R3 reported that had been "slow" and could get her cares of had reported that wh for R31 she gone in t cares. LPN-B said R3 walked into R3's roor upset and had a neg said R3 reported that comment, "If you we residents] so lazy or for R3. LPN-B said a about the incident, L1 DON so she could al allegations of abuse. with R3 and F-A, with					
	a.m., LPN-A stated N 10/26/13, following p R3, that R3 was upso (NA-E) to provide can having spoken to R3	rovision of care for R31 and et and reluctant to allow her re. LPN-A acknowledged and having been made				
	had treated R31 and allegation had not be the DON, LSW or ad confirmed the incider the State agency, tha investigation, nor had	t's concerns about how NA-E herself. LPN-A verified the een immediately reported to ministrator, and LPN-A ht had not been reported to at LPN-A had not initiated an d LPN-A implemented any ns for R3 or R31. LPN-A did				

STATEMENT	a Department of Healt OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			B. WING				
	ROVIDER OR SUPPLIER	00145	TREET ADDRESS, CITY, STATE, ZIP CODE			/01/2013	
	SUNSET HOME		NDERSON BOULEV				
		KENYOI	N, MN 55946				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
22000	Continued From page	e 43	22000				
	not think R3's compla reporting.	aints met the criteria for					
	been employed from year off, and had bee performance evaluat an action plan of, "no are busy" and the ev included, "Stay out o professional." NA-E' included a document where two residents and rude treatment. indicated NA-E had s so hurry up." NA-E h to be respectful and o corrective action report NA-E had not provide cares to a resident so ready at 1:00 p.m. to action plan directed h family and pay attent corrective action report had received any add rights, time managen skills. On 10/31/13 at administrator verified with the way NA-E tre identified.	s personnel record also ed incident dated 9/21/11, had complained of rough The incident documentation stated, "We are short staffed had been verbally counseled considerate of residents. A bott dated 2/1/12, indicated ed the necessary personal to that the resident could be go to an appointment. The NA-E to apologize to the ion to resident needs. The botts did not indicate NA-E ditional training on resident ment, or communication					
	During the interview,	on 10/30/13 at 5:00 p.m. R31 did not acknowledge any abuse, but stated there					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
			B. WING			
	ROVIDER OR SUPPLIER	00145	DDRESS, CITY, STATE		11	/01/2013
	SUNSET HOME		IDERSON BOULE			
			N, MN 55946			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
22000	Continued From page	e 44	22000			
	light, and that she ha	gh staff to answer her call d to wait for long periods of nce with care including et.				
	The administrator and been unaware of the reported by R3 until to to their attention. The reported the allegation the administrator or to become aware of R3 The LSW and DON w initiated a thorough in of abuse reported by R31, other residents, after this issue was b administrative staff of were implemented to further potential abus	up on 10/30/13 at 4:30 p.m. d LSW again stated they had alleged allegation of abuse he surveyors had brought it e DON verified she had not on of abuse immediately to o OHFC when she had first 's allegation on 10/28/13. verified that no one had nvestigation of the allegation R3, such as interviewing and staff. It was not until rought to the attention of the n 10/30/13, that interventions protect R31 and R3 from se while an investigation was ncident was reported to the				
	by staff and had repo said nothing had bee investigation the repo	f rough treatment provided orted this to other staff, but n done about it. On further ort of alleged allegation of immediately reported to the nor an investigation				
	a score of 15 indication cognitive impairment	ed on 8/13/13, that identified ng the resident had not . The quarterly MDS dated e resident required extensive				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00145         NAME OF PROVIDER OR SUPPLIER       STREET A		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING				
		ADDRESS, CITY, STATE, ZIP CODE		11	11/01/2013		
			IDERSON BOULEV				
(ENYON S	SUNSET HOME	KENYON	I, MN 55946				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLET DATE	
22000	Continued From page 45		22000				
	stated that staff would bed rail while dressin manager had been to manager said she har rough treatment, but i have trouble with bein R6 was observed dur 10/30/13 from 8:00 an provided by NA-E. R large bed with side ra rolled R6 from side to provided cares. No co roughly into the rails of During an interview o was again questioned rough treatment. R6 help roll her from side down too hard using to keep R6 from rolling I have red marks on her rough. R6 stated she handling to the nurse seemed like nothing If the rough treatment of this surveyor if she co person had been roug identified NA-E by na had roughly handled	m to 8:30 a.m. Cares were 6 was observed lying in a ils in the up position. NA-E side four times, and oncerns with NA-E rolling R6 was observed. In 10/30/13 at 4:55 p.m. R6 d about her concerns about explained that staff would e to side, and then press the sides of their hands to back. R6 stated she would er hands from staff being too had reported this rough "more than once," and it had been done about it as continued. R6 was asked by buld identify which staff gh with her, and R6 me, as the sole person who					
	9:40 a.m., R6 again s into the side rail on n	tated she had been rolled umerous occasions by she had reported the rough					
		n 10/31/13 at 9:45 a.m. not remember having been					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00145			11/01/2013		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	r ADDRESS, CITY, STATE, ZIP CODE				
KENYON	SUNSET HOME		NDERSON BOULEV N, MN 55946	ARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLET D THE APPROPRIATE DATE		
22000	Continued From page 46		22000				
	told about the rough treatment experienced by R6.						
	not heard about issue rough treatment durin was the procedure fo abuse or neglect the routine would have be the administrator and Then she and the DC incident and write a re During an interview of administrator stated H policy and procedure the charge nurse the responsible to protect investigation was corn nurse was to contact the LSW was to file the administrator. The ad- reporting directions was station for all staff to a verified she was not a immediately notified re abuse. SUGGESTED METH The Director of Nurse could provide educati regarding reporting re implementing the pro Prevention Policy and	In 10/30/13 at 11:15 a.m., the her understanding of the VA had been for staff to notify in the charge nurse was t the resident until the inpleted. That the the charge the DON or LSW, and that he report and contact the dministrator stated the vere available at the nursing use. The administrator aware that she had to be regarding allegations of IOD FOR CORRECTION: es and/ or the Social Worker ion and training to all staff					