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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EUPC
Facility ID: 00145

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245379**

2. STATE VENDOR OR MEDICAID NO. (L2) **779040600**

3. NAME AND ADDRESS OF FACILITY
(L3) **KENYON SUNSET HOME**
(L4) **127 GUNDERSON BOULEVARD**
(L5) **KENYON, MN** (L6) **55946**

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/30/2013** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **38** (L18)

13.Total Certified Beds **38** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	38			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 12/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/12/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/26/2013
(L33)

DETERMINATION APPROVAL

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,

Anne Kleppe

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.

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, 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

Revised 2567B to show correction of # F0356

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing	12/30/2013

Name of Facility	Street Address, City, State, Zip Code
KENYON 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	**12/30/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**12/30/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**12/30/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	**12/30/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**12/30/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**12/30/2013**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	**12/30/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	**12/11/2013**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	**12/30/2013**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	**12/30/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	MM/GPN	02/02/2014	19694	12/30/2013
Reviewed By CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/1/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing	12/30/2013

Name of Facility	Street Address, City, State, Zip Code
KENYON 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**12/30/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**12/30/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**12/30/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	**12/30/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**12/30/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**12/30/2013**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	**12/30/2013**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	**12/30/2013**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	**12/30/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GPN	02/02/2014	19694	12/30/2013

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/1/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing 01 - MAIN BUILDING 01	12/16/2013

Name of Facility	Street Address, City, State, Zip Code
KENYON 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	12/04/2013	ID Prefix Reg. # NFPA 101 LSC K0050	12/05/2013	ID Prefix Reg. # NFPA 101 LSC K0071	12/11/2013
ID Prefix Reg. # NFPA 101 LSC K0147	10/31/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	02/02/2014	25822	12/16/2013
CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/30/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent 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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing	12/30/2013

Name of Facility	Street Address, City, State, Zip Code
KENYON 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**12/30/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**12/30/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**12/30/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	**12/30/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**12/30/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**12/30/2013**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	**12/30/2013**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	**12/30/2013**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	**12/30/2013**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GPN	02/02/2014	19694	12/30/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
11/1/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: EUPC
Facility ID: 00145

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245379**
2. STATE VENDOR OR MEDICAID NO. (L2) **779040600**

3. NAME AND ADDRESS OF FACILITY
(L3) **KENYON SUNSET HOME**
(L4) **127 GUNDERSON BOULEVARD**
(L5) **KENYON, MN** (L6) **55946**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **11/01/2013** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
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, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **38** (L18)
13. Total Certified Beds **38** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	38			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 12/13/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/24/2013 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN=245379

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.

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 only a suggestion 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, 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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245379	A. BUILDING ______ B. WING ______	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENYON SUNSET HOME	127 GUNDERSON BOULEVARD KENYON, MN 55946

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Minnesota Department of Health on October 28-November 1, 2013. The survey resulted in an Immediate Jeopardy (IJ) at F225 related to the facility's failure to respond to resident allegations of mistreatment/ abuse which resulted in the high potential for harm or death. Facility staff were notified of the IJ on 10/30/13, at 5:20 p.m. for the IJ that began on 10/26/13. The IJ was removed on 10/31/13, at 4:30 p.m., however non-compliance remained at the lower s/s of a D. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000 12/09/13 [illegible]		
F 225 SS=J	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225	**F 225** Kenyon Sunset Home strives to ensure that each resident's allegation of abuse, neglect, mistreatment or misappropriation of their property is reported immediately to facility Administrator and person in charge.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chelsea R. Ugland
TITLE: Acting Administrator
(X6) DATE: 12/5/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report to the administrator, immediately report to the designated State agency, complete a thorough investigation and failed to protect 3 of 5 residents (R31, R3 and R6) reviewed for abuse/neglect allegations. R3 reported being afraid of a nursing assistant after hearing the nursing assistant speak harshly to a neighboring resident (identified as R31) during morning cares. Even though this allegation of abuse was reported to facility staff	F 225	1) R3 and R6 comprehensive assessment and care plan have been reviewed regarding abuse and neglect allegations. R31 has been discharged to home. Corrective action was put in place on October 30, 2013. Kenyon Sunset Home policy requires that all alleged violations involving resident mistreatment, neglect, and abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator, person in charge and appropriate state agencies and 2) thoroughly investigated within five days with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process and ensures that residents are safe.	

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F 225	Continued From page 2 following the incident, the facility did not immediately act upon the report and did not protect R31 or R3 from further potential abuse. During this time the identified nursing assistant (NA)-E continued to work with these residents for several more days before the survey agency brought this to the facility's attention, at which time NA-E had been suspended from work while an investigation was conducted. The findings resulted in an Immediate Jeopardy (IJ)situation for 1 of 5 residents (R3) reviewed for allegations of abuse. In addition, all other residents remained at risk of potential harm, verbal abuse, that is not immediate jeopardy, as NA-E had the potential to work unsupervised with all residents in the facility. The immediate jeopardy began on 10/26/13, when a licensed practical nurse (LPN)-A was made aware of an allegation of abuse and failed to internally report, investigate, report to the designated State agency (Office of Health Facility Complaints-OHFC), and protect the involved residents. Consequently, the alleged perpetrator (NA-E) continued working with the residents for several days. The administrator, director of nursing, and licensed social worker (LSW) were notified of the immediate jeopardy on 10/30/13 at 5:20 p.m. The immediate jeopardy was removed on 10/31/13 at 4:30 p.m. however, noncompliance remained at the lower scope and severity level of an F-a pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R3 was interviewed on 10/28/13 at 2:54 p.m. During the interview, R3 was asked whether or not she or anyone else in the facility had been abused. R3 had immediately	F 225	2) All Kenyon Sunset Home residents residing in the facility will be updated on Vulnerable Adult policy and procedures. Residents will also be updated on how to report and who to report to and types of abuse (example neglect, abuse, mistreatment, etc.). 3) Kenyon Sunset Home staff has been re-educated on Vulnerable Adult policy, procedures and how and who to immediately report to when an allegation of abuse occurs. 4) To ensure all employees' understanding, knowledge and compliance with these policies, Department Managers will perform on a weekly basis for a six month duration and thereafter quarterly as needed review and questioning of policies and procedures. Completion of mandated yearly in-services will be scheduled on a monthly basis for all employees. All in-services will include a discussion and review of these policies.	

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F 225	Continued From page 3 responded, "Yes" to the question and on further interview with R3 it was learned that R3 had overheard a conversation between a NA-E and R31 who lived next door to her. R3 went on to say that NA-E told R31 to get her own blouse on and if she didn't, the staff would come back and GET IT ON FOR HER in a loud and threatening tone of voice. R3 said she'd also heard NA-E call R31 "lazy." NA-E had completed cares for R31 and went into R3's room at which time R3 stated that NA-E "was at me." R3 stated NA-E had entered her bedroom and had stated, in a sarcastic and threatening tone, "This is the third time I have been in here!" R3 said NA-E had made that comment after R3 had requested more washcloths since she had used her last one. R3 said that because of 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 didn't mention my back. She [NA-E] was so angry and she [NA-E] went out of here storming. I don't know why she was so angry." R3 stated she had spoken to licensed practical nurse (LPN)-A about her concerns on 10/26/13 but nothing had been done. R3 then stated her daughter family (F) member-A had stopped in to see her today and added, "They [reference to the director of nursing (DON) and licensed practical nurse (LPN)-B] are on it today. The boss [reference to DON] came down here and talked to me and my daughter (F-A) was here and heard the story. I didn't like to be a tattle tale but I didn't like the action she [NA-E] took. I tried hard to dress faster, but I can't put on my arm thing and elastic stockings myself." R3 indicated that because of the way NA-E was acting, she had tried to dress faster on Saturday so she would not upset NA-E when she came in to help her with her care.	F 225	5) Completion date: ~~January 14, 2014.~~	December 11, 2013 [initials]

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F 225	Continued From page 4 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.	F 225		

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F 225	Continued From page 5 The DON stated that R3 kept repeating that NA-E was angry and that NA-E had torn the privacy curtain in R3's room. The DON stated she had spoken with NA-E yesterday (10/29/13) after having met with R3 and her family, and had informed NA-E her behavior had been tormenting and belittling to R31 and R3. The DON confirmed she had not documented the alleged abuse reported by R3 nor had she documented the interview with NA-E. The DON verified that neither she nor LPN-B had immediately informed the administrator or the State agency about the allegations. In addition, the DON verified there had been no interventions put in place to protect R3 and R31 from potential ongoing abuse by NA-E, and that NA-E had been allowed to continue working un-supervised, caring for these two residents and others in the facility. The DON verified that she was new to her position at the facility, and had not felt R3's allegation met the criteria for reporting. During an interview on 10/30/13 at 1:35 p.m., the licensed social worker (LSW) stated she was unaware of the alleged abuse R3 had reported to LPN-A, LPN-B and the DON. After interviewing the LSW, the LSW went to speak to the DON. At 1:40 p.m., the LSW approached the surveyor and stated the DON had "addressed the situation." The LSW verified there was no documented record of the alleged 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 had received two previous warnings in the past related to rough and rude behavior toward residents. The LSW also stated she was responsible for staff training regarding issues	F 225		

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F 225	Continued From page 6 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	F 225		

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F 225	Continued From page 7	F 225		

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 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.

NA-E's personnel file was reviewed. NA-E had been employed from 2008 to 2009, had taken a

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F 225	Continued From page 8 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 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 weren't always enough staff to answer her call light, and that she had to wait for long periods of time for staff assistance with care including assistance to the toilet.	F 225		

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F 225	Continued From page 9	F 225		

The administrator, LSW and DON were interviewed as a group on 10/30/13 at 4:30 p.m. The administrator and LSW again stated they had been unaware of the alleged allegation of abuse reported by R3 until the surveyors had brought it to their attention. The DON verified she had not reported the allegation of abuse immediately to the administrator or to OHFC when she had first become aware of R3's allegation on 10/28/13. The LSW and DON verified that no one had initiated a thorough investigation of the allegation of abuse reported by R3, such as interviewing R31, other residents, and staff. It was not until after this issue was brought to the attention of the administrative staff on 10/30/13, that interventions were implemented to protect R31 and R3 from further potential abuse while an investigation was conducted, and the incident was reported to the State agency late on 10/30/13.

R6 had complaints of rough treatment provided by staff and had reported this to other staff, but said nothing had been done about it. On further investigation the report of alleged allegation of abuse had not been immediately reported to the administrator, OHFC nor an investigation completed.

Record review indicated R6 had a BIMS assessment conducted on 8/13/13, that identified a score of 15 indicating the resident had not cognitive impairment. The quarterly MDS dated 8/13/13, indicated the resident required extensive assistance from staff with all ADLs.

During an interview on 10/28/13 at 6:46 p.m., R6 stated that staff would "Roughly roll" them into the bed rail while dressing. R6 stated that the case

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	245379	A. BUILDING ____ B. WING ____	11/01/2013

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F 225	Continued From page 10 manager had been told about it and that the case manager said she had talked to staff about the rough treatment, but R6 stated she continued to have trouble with being rolled into the side rail. R6 was observed during morning cares on 10/30/13 from 8:00 am to 8:30 a.m. Cares were provided by NA-E. R6 was observed lying in a large bed with side rails in the up position. NA-E rolled R6 from side to side four times, and provided cares. No concerns with NA-E rolling R6 roughly into the rails was observed. During an interview on 10/30/13 at 4:55 p.m. R6 was again questioned about her concerns about rough treatment. R6 explained that staff would help roll her from side to side, and then press down too hard using the sides of their hands to keep R6 from rolling back. R6 stated she would have red marks on her hands from staff being too rough. R6 stated she had reported this rough handling to the nurse "more than once," and it seemed like nothing had been done about it as the rough treatment continued. R6 was asked by this surveyor if she could identify which staff 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-A. During an interview on 10/31/13 at 9:45 a.m. LPN-A stated she did not remember having been told about the rough treatment experienced by R6.	F 225		

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F 225	Continued From page 11 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 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 immediately if: i. One has knowledge of maltreatment/neglect of a resident..." Under How to report a suspected incident of abuse/neglect, the policy read, "Report all alleged violations and substantiated incidents to the administrator and in his/her absence contact the designated in charge 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	F 225		

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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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F 225	Continued From page 13 immediately with the staff currently working then the managers were directed to call all other employees; education was to be documented to include that the employee was contacted, and acknowledged an understanding of the policies. Implementation of this plan was verified by review of policies and interview of staff. The immediate jeopardy was removed on 10/31/13 at 4:30 p.m. however, noncompliance remained at the lower scope and severity level of an F (corresponds to a pattern on the scope and severity grid used by nursing home determination of compliance) , which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their Abuse Prevention Policy which indicated allegations of abuse were to be immediately reported to the administrator, reported to the State agency, failed to initiate an investigation, and failed to implement measures to protect residents involved 3 of 3 residents (R3, R31, R6) who were reviewed for allegations of abuse. This deficient had the potential to affect all 27 residents residing in the facility who were vulnerable to abuse due to staff failure to	F 226	**F 226** Kenyon Sunset Home strives to ensure that each resident's allegation of abuse, neglect, mistreatment or misappropriation of their property is reported immediately to facility Administrator and person in charge according to the Vulnerable Adult policy and procedures the prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	

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F 226	Continued From page 14 implement their policies. Findings include: 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 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 immediately if: i. One has knowledge of maltreatment/neglect of a resident..." Under How to report a suspected incident of abuse/neglect, the policy read, "Report all alleged violations and substantiated incidents to the administrator and in his/her absence contact the designated in charge 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 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	F 226	1) R3 and R6 comprehensive assessment and care plan have been reviewed regarding abuse and neglect allegations. R31 has been discharged to home. Corrective action was put in place on October 30, 2013. Kenyon Sunset Home policy requires that all alleged violations involving resident mistreatment, neglect, and abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator, person in charge and appropriate state agencies and 2) thoroughly investigated within five days with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process and ensures that residents are safe.	

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F 226	Continued From page 15 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." R3 was interviewed on 10/28/13 at 2:54 p.m. During the interview, R3 was asked whether or not she or anyone else in the facility had been abused. R3 had immediately responded, "Yes" to the question and on further interview with R3 it was learned that R3 had overheard a conversation between a NA-E and R31 who lived next door to her. R3 went on to say that NA-E told R31 to get her own blouse on and if she didn't, the staff would come back and GET IT ON FOR HER in a loud and threatening tone of voice. R3 said she'd also heard NA-E call R31 "lazy." NA-E had completed cares for R31 and went into R3's room at which time R3 stated that NA-E "was at me." R3 stated NA-E had entered her bedroom and had stated, in a sarcastic and threatening tone, "This is the third time I have been in here!" R3 said NA-E had made that comment after R3 had requested more washcloths since she had used her last one. R3 said that because of 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 didn't mention my back. She [NA-E] was so angry and she [NA-E] went out of here storming. I don't know why she was so angry." R3 stated she had spoken to licensed practical nurse (LPN)-A about her concerns on 10/26/13 but nothing had been done. R3 then stated her daughter family (F) member-A had	F 226	2) All Kenyon Sunset Home residents residing in the facility will be updated on Vulnerable Adult policy and procedures. Residents will also be updated on how to report and who to report to and types of abuse (example neglect, abuse, mistreatment, etc.). 3) Kenyon Sunset Home staff has been re-educated on Vulnerable Adult policy, procedures and how and who to immediately report to when an allegation of abuse occurs. 4) To ensure all employees' understanding, knowledge and compliance with these policies, Department Managers will perform on a weekly basis for a six month duration and thereafter quarterly as needed review and questioning of policies and procedures. Completion of mandated yearly in-services will be scheduled on a monthly basis for all employees. All in-services will include a discussion and review of these policies.	

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F 226	Continued From page 16 stopped in to see her today and added, "They [reference to the director of nursing (DON) and licensed practical nurse (LPN)-B] are on it today. The boss [reference to DON] came down here and talked to me and my daughter (F-A) was here and heard the story. I didn't like to be a tattle tale but I didn't like the action she [NA-E] took. I tried hard to dress faster, but I can't put on my arm thing and elastic stockings myself." R3 indicated that because of the way NA-E was acting, she had tried to dress faster on Saturday so she would not upset NA-E when she came in to help her with her care. R3's record was revived. 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	F 226	5) Completion date: ~~January 14, 2014.~~	December 11, 2013 [handwritten initials]

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F 226	Continued From page 17 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. The DON stated that R3 kept repeating that NA-E was angry and that NA-E had torn the privacy curtain in R3's room. The DON stated she had spoken with NA-E yesterday (10/29/13) after having met with R3 and her family, and had informed NA-E her behavior had been tormenting and belittling to R31 and R3. The DON confirmed she had not documented the alleged abuse reported by R3 nor had she documented the interview with NA-E. The DON verified that neither she nor LPN-B had immediately informed the administrator or the State agency about the allegations. In addition, the DON verified there had been no interventions put in place to protect R3 and R31 from potential ongoing abuse by NA-E, and that NA-E had been allowed to continue working un-supervised, caring for these two residents and others in the facility. The DON verified that she was new to her position at the facility, and had not felt R3's allegation met the criteria for reporting. During an interview on 10/30/13 at 1:35 p.m., the licensed social worker (LSW) stated she was unaware of the alleged abuse R3 had reported to	F 226		

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F 226	Continued From page 18 LPN-A, LPN-B and the DON. After interviewing the LSW, the LSW went to speak to the DON. At 1:40 p.m., the LSW approached the surveyor and stated the DON had "addressed the situation." The LSW verified there was no documented record of the alleged 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 had received two previous warnings in the past related to rough and rude behavior toward residents. The LSW also stated she was responsible for staff training regarding issues 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	F 226		

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F 226	Continued From page 19 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	F 226		

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F 226	Continued From page 20 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. 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 identified.	F 226		

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F 226	Continued From page 21	F 226		

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 weren't always enough staff to answer her call light, and that she had to wait for long periods of time for staff assistance with care including assistance to the toilet.

The administrator, LSW and DON were interviewed as a group on 10/30/13 at 4:30 p.m. The administrator and LSW again stated they had been unaware of the alleged allegation of abuse reported by R3 until the surveyors had brought it to their attention. The DON verified she had not reported the allegation of abuse immediately to the administrator or to OHFC when she had first become aware of R3's allegation on 10/28/13. The LSW and DON verified that no one had initiated a thorough investigation of the allegation of abuse reported by R3, such as interviewing R31, other residents, and staff. It was not until after this issue was brought to the attention of the administrative staff on 10/30/13, that interventions were implemented to protect R31 and R3 from further potential abuse while an investigation was conducted, and the incident was reported to the State agency late on 10/30/13.

R6 had complaints of rough treatment provided by staff and had reported this to other staff, but said nothing had been done about it. On further investigation the report of alleged allegation of

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abuse had not been immediately reported to the administrator, OHFC nor an investigation completed.

Record review indicated R6 had a BIMS assessment conducted on 8/13/13, that identified a score of 15 indicating the resident had not cognitive impairment. The quarterly MDS dated 8/13/13, indicated the resident required extensive assistance from staff with all ADLs.

During an interview on 10/28/13 at 6:46 p.m., R6 stated that staff would "Roughly roll" them into the bed rail while dressing. R6 stated that the case manager had been told about it and that the case manager said she had talked to staff about the rough treatment, but R6 stated she continued to have trouble with being rolled into the side rail.

R6 was observed during morning cares on 10/30/13 from 8:00 am to 8:30 a.m. Cares were provided by NA-E. R6 was observed lying in a large bed with side rails in the up position. NA-E rolled R6 from side to side four times, and provided cares. No concerns with NA-E rolling R6 roughly into the rails was observed.

During an interview on 10/30/13 at 4:55 p.m. R6 was again questioned about her concerns about rough treatment. R6 explained that staff would help roll her from side to side, and then press down too hard using the sides of their hands to keep R6 from rolling back. R6 stated she would have red marks on her hands from staff being too rough. R6 stated she had reported this rough handling to the nurse "more than once," and it seemed like nothing had been done about it as the rough treatment continued. R6 was asked by this surveyor if she could identify which staff

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F 226	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 stated the reporting directions were available at the nursing station for all staff to use. The administrator verified she was not aware that she had to be immediately notified regarding allegations of abuse.	F 226		

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F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a resident specific comprehensive care plan for 2 of 4 residents (R3, R36) who were newly admitted to the facility. Findings include: R3 did not have a comprehensive care plan developed 21 days after admission. R3 was admitted on 9/25/2013 with diagnoses which included: macular degeneration (blindness), high blood pressure, chronic pain,	F 280	**F 280** Kenyon Sunset Home strives to ensure that each resident has a comprehensive care plan developed and completed by the interdisciplinary team 21 days after admission to the facility. 1) R3, R36 care plans will be updated and completed per resident preference. 2) All Kenyon Sunset Home residents will have their care plans updated and completed per resident preference. Residents' needs will be reviewed and revised as indicated. 3) The interdisciplinary team has been re-educated on facility protocol on plan of care completion procedures. 4) Random weekly visual audits will be completed. Licensed Social Worker will monitor for compliance.	

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F 280	Continued From page 25 GERD (gastro-esophageal reflux disease), depression, and chronic renal insufficiency stage 3. A temporary care plan dated 9/25/2013 was provided and it addressed limited mobility related to macular degeneration, bowel and bladder, chronic pain, altered nutrition related to diabetes, cellulitis of left arm and abscess, altered comfort related to chronic pain, falls related to macular degeneration, and potential for medications side effects. It did not address vision, communication, psychosocial wellbeing, activities, or vulnerable adult related to abuse/neglect. The admission Minimum Data Set dated 10/1/2013 identified the resident's cognitive status as alert and oriented. The functional status of the resident for activities of daily living (ADL) identified as limited assist of one staff except for extensive assist of one staff for dressing, toileting and independent in eating once set up. On 10/30/2013 at 2:15 p.m., the director of nursing (DON) was interviewed regarding the lack of a comprehensive care plan for R3. According to the DON, R3 did not have a comprehensive care plan; however, R3 did have a temporary care plan. R36 did not have a comprehensive care plan developed after admission. R36 was admitted on 9/25/2013 with general	F 280	5) Completion date: ~~January 14, 2014.~~	December 11, 2013 [initials]

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F 280	Continued From page 26 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. R36's care plan with original date of 10/16/2013 did not include interventions and treatments to address the triggered areas identified on the admission Minimum Data Set (MDS) dated 10/1/13 which included: delirium, cognition, vision, communication, activities of daily living (ADL)s function/rehab potential, bowel and bladder, mood state, falls, nutritional/dehydration, oral/dental care, pressure ulcers/skin, psychotropic drug use, physical restraints, other specific needs/medications used, pain management. On 10/30/2013 at 12:40 p.m., the licensed social worker verified the care plan provided to the surveyor was computer generated and the most up to date the facility had. Facility policy dated 3/1/2008 for Admission/Readmission of the Resident Policy and Procedure was reviewed and noted: Under Forms to be completed on admission: 1. Individual Resident care plan should be started on admission. Complete care plan to be completed within 21 days of admission.	F 280	**F 309** Kenyon Sunset Home strives to ensure that each resident receive 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. Kenyon Sunset Home strives to ensure an effective pain management regimen and comprehensive pain assessment is completed to control chronic pain for our residents. 1) R12 comprehensive care plan and pain assessment has been reviewed and updated. Pain management has been implemented.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309	2) All Kenyon Sunset Home residents will have their plan o f care updated to ensure services are being met. Residents needs will be reviewed and revised as indicated.	

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F 309	Continued From page 27 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure an effective pain management regimen and comprehensive 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 quarterly Minimum Data Set (MDS) dated	F 309	3) All nursing department staff has been re-educated on effective pain management regimen and plan of care. 4) Director of Nursing will routinely monitor for compliance. 5) Completion date: ~~January 14, 2014.~~	December 11, 2013 APN

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F 309	Continued From page 28 8/6/13 indicated a BIMS (brief intellectual mental status) score of 14 to 15 which meant R12 had no cognitive impairment. The MDS identified R12 had constant pain rated as a 6 on a scale of 0 to 10 with 10 as worst pain and received as needed pain (PRN) medications. This has been a change from the 5/7/13 quarterly MDS where R12 had not received PRN pain medications. The 8/6/13 MDS also identified R12 as requiring extensive assist with bed mobility, dressing, and toileting and otherwise was independent. Also R12 used a walker to ambulate. The Resident Pain Interview form dated 8/6/13 identified R12 as having pain almost constantly in the left hip, had trouble sleeping because of the pain, rated the pain at 6 on a scale of 10, but was unable to identify the intensity of the pain over the past 5 days. The Resident Pain Interview also noted R12 had no scheduled pain medications. This assessment had not identified potential physical, clinical, or environmental risk factors potentially causing R12's pain to determine what interventions both non-pharmacological and medication use to control pain. Narrative nursing notes dated 8/17/13, 8/27/13 and 10/14/13 identified R12 as having left hip pain. These notes had not assessed the potential factors causing the pain or what non-pharmacological and pain medication interventions were utilized to manage pain. R12 ' s care plan dated 10/31/13 identified a problem of pain management including chronic pain in left hip. The approaches included administer scheduled/PRN pain medications (although R12 had no scheduled pain medications at this time), pain assessment	F 309		

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F 309	Continued From page 29 quarterly, update the doctor, call light in reach, monitor for effectiveness of pain medication, encourage mobility, offer non-pharmacological measure for pain relief (there was not specific non-pharmacological interventions identified such as ice, heat, message, movement, etc.) The director of nursing (DON) was interviewed on 11/1/13 at 8:45 a.m. and indicated R12 was able to tell the staff when having pain. DON stated R12 would isolate self in their room after family visits or due to being "Just too darn sore" in reference to hip pain. DON verified no scheduled pain medication had been attempted only PRN. On 11/1/13 at 3:45 p.m. the licensed social worker and RN-B indicated they had not completed a pain assessment to evaluate if uncontrolled pain management had contributed to R26 ' s depression and excess sleep.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assistance with personal hygiene was provided for 1 of 3 resident (R6) reviewed who required assistance with activities of daily living. Findings include:	F 312	**F 312** Kenyon Sunset Home strives to carry out activities of daily living by providing necessary services to maintain good nutrition, grooming, and personal and oral hygiene for all residents. 1) R6 care plan has been reviewed and updated to ensure resident preference, which includes grooming and personal hygiene.	

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F 312	Continued From page 30 R6 did not receive assistance with morning personal cares. R6 was observed on 10/30/13 from 8:00 a.m.to 8:30 a.m. while nursing assistant (NA)-E provided morning cares to help R6 get ready for breakfast. NA-E obtained a wet washcloth from the bathroom and provided peri-care to the resident. NA-E stated R6 was not able to use the peri wet wipes independently. NA-E then positioned and fastened an incontinent brief, rolled R6 in bed to put slacks on and then proceeded to put R6's socks and slippers on. With assistance from a second NA, R6 was transferred from bed to the wheelchair using the mechanical lift. NA-E then assisted to dress the upper portion of R6 ' s body, handed R6 dentures and left the room and did not return to assist R6 to wash her face, hands, or underarms. On 10/31/13 at 10:00 a.m. R6 stated they preferred to be washed up in the morning with soap and water. R6 then stated the staff doesn ' t always have time to wash her body with mourning cares and sometimes not at bed time either. R6's quarterly Minimum Data Set dated 8/13/13 noted R6 required extensive assist to total assistance for completing activities of daily living such as bathing and personal cares also had no cognitive impairment. R6's care plan dated 10/31/13 directed staff that R6 required extensive assist of one staff to dress and dependent on staff for grooming needs. During an interview on 10/31/13 at 9:45 a.m. about what morning cares were to be done for the resident, NA-F stated that morning cares	F 312	2) All Kenyon Sunset Home residents will have their care plans reviewed and updated per resident preference, which includes grooming and person hygiene. Residents' needs will be reviewed and revised as indicated. 3) The nursing department staff has been re-educated on facility protocol on grooming and personal hygiene along with following the plan of care. 4) Random visual audits will be completed. Director of Nursing will monitor for compliance. 5) Completion date: ~~January 14, 2014.~~	December 11, 2013 SPN

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F 312	Continued From page 31 consisted of washing face, hands, under arms, and under breasts. NA-F stated R6 would usually allow staff to do this when morning cares were done. The facility provided an undated policy entitle A.M. Cares that read, "6. Wash resident's face, hands and underarms and dry well." During an interview on 10/30/13 at 4:00 p.m. the director of nursing stated that morning cares would include washing of face, under breasts and under arms.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F 329** Kenyon Sunset Home strives to ensure that each resident's comprehensive assessment will ensure the residents who do not use antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary. 1) R26 plan of care has been reviewed and updated to include effectiveness of PRN medications, parameters along with follow-up documentation.	

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F 329	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure as needed (PRN) pain medication and antianxiety medications were monitored for effectiveness for 1 of 5 residents (R26) reviewed for unnecessary drugs and the facility failed to administer the antianxiety medication as directed in the care plan protocol for 1 of 5 residents (R26) reviewed for unnecessary drugs. Findings include: R26 received PRN Roxanol (is a morphine medication used to treat moderate to severe pain) and Ativan (antianxiety medication) without consistent monitoring of effectiveness of 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. R26's care plan identified a problem of psychotropic drug use and listed behaviors as refusal of peri-cares after incontinence episode, yelling out at staff and other residents. The	F 329	2) All Kenyon Sunset Home residents will have their care plans evaluated and updated to include PRN effectiveness regarding the use of psychotropic medications. The pharmacist will review psychotropic medications. 3) All nursing department staff has been re-educated on plan of care, PRN usage and effectiveness, psychotropic medications, and documentation. 4) Random visual audits will be completed. Director of Nursing will monitor for compliance. 5) Completion date: ~~January 14, 2014.~~	December 11, 2013 [initials]

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	245379	A. BUILDING ______ B. WING ______	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENYON SUNSET HOME	127 GUNDERSON BOULEVARD KENYON, MN 55946

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33	F 329		

interventions for these behaviors were to give medications as ordered; rule out pain by offering and administering Roxanol when anxious or agitated. If no decrease in behaviors in 30 minutes, then give PRN Ativan.

The medication administration records (MAR) were reviewed for August 2013 through October 2013. August ' s MAR showed R26 received Roxanol 5 times and Ativan 12 times. The Roxanol was given prior to the Ativan only twice out of 12 opportunities. In September the MAR showed R26 received Roxanol 5 times and Ativan 19 times and the Roxanol had been given only once out of 19 opportunities. In October the MAR showed R26 received Roxanol 1 time and Ativan 8 times and the Roxanol had been given 0 times out of 8 opportunities.

The nursing documentation for August 1, 2013 through October 29, 2013 had been reviewed. 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

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F 329	Continued From page 34 and effectiveness or lack of effectiveness of the medication given. The director of nursing (DON) was interviewed on 11/1/13 at 8:40 a.m. DON stated staff was not following through with the PRN directions as outlined on the care plan or documentation the PRN usage.	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate	F 353	**F 353** Kenyon Sunset Home strives to ensure sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 1) R1 and R32 have passed away. R31 has discharged to home. R3, R6, and R23 will be assured assistance during meal times and with activities of daily living (ADL) needs. R6 care plan has been reviewed and updated to ensure resident preference, which includes grooming and personal hygiene.	

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F 353	Continued From page 35 nursing staff to provide resident cares based on the resident's assessed need for assistance including but not limited to eating and dining for 6 of 6 residents (R32, R1, R23, R6, R31 and R3) assessed to need assistance with activities of daily living (ADL) needs. Findings include: R31, R1 and R6 and the other 24 residents were observed during the supper meal on 10/28/13 from 5:35 p.m. to 6:10 p.m. There were eight residents which included R31, R1 and R6 who were assessed to need assistance to eat. There were three nursing assistants (NA) in the dining room and one licensed practical nurse (LPN) was in and out of the dining room and had not assisted any resident with eating. All meals were dished up and delivered to each resident by 5:49 p.m. There were two NAs assisting the four residents at a table to eat. R31, R1 and R6 were seated at a different table which was located next to the table where the two NAs were assisting residents to eat. R31, R1 and R6 were assessed to need assistance to eat and had been unassisted to eat while their food had been placed in front of them on the table. The fourth resident at the table ate independently while R31, R1 and R6 watched. At 6:00 p.m. which was 11 minutes after the food was placed in front of R31, R1 and R6 NA-B sat at the table and began to help them eat. NA-B was observed to frequently stand and change chairs to help all three eat a few bites of food then move to the next resident repeating this rotation until R31, R1 and R6 had completed eating. The director of nursing (DON) was interviewed on	F 353	2) All Kenyon Sunset Home residents will have their care plans reviewed and updated per resident preference, which includes grooming and person hygiene. Residents' needs will be reviewed and revised as indicated. All Kenyon Sunset Home residents will be provided with assistance during meal times. 3) The interdisciplinary team has been re-educated on facility protocol to ensure uninterrupted assistance during mealtime. The nursing department staff has been re-educated on facility protocol for grooming and personal hygiene along with following the plan of care. 4) Random visual audits will be completed. Administrator or Director of Nursing will monitor for compliance. 5) Completion date: ~~January 14, 2014~~.	December 11, 2013 [initials]

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F 353	Continued From page 36 10/28/13 at 6:30 p.m. concerning the staffing in the dining room for this meal. DON stated that this would be the " normal " staffing for the shift. R6 lacked services with personal cares as needed. During an interview on 10/28/13 at 7:10 p.m. R6 stated have had to wait for 40 minutes to get help when they turn the call light on so they can get to the bathroom timely. On further interview it was learned that R6 had had bowel incontinence while waiting for help. R6 stated doesn't feel good about that. R6 was observed on 10/30/13 from 8:00 a.m. to 8:30 a.m. while nursing assistant (NA)-E provided morning care. NA-E provided peri-care with a wet washcloth, assisted R6 to get dressed, and then transferred R6 to wheelchair. However, R6 had not washed or encouraged R6 to wash face, hands, or underarms. On 10/31/13 at 10:00 a.m. R6 stated would have preferred to be washed up completely in the morning but R6 stated that doesn ' t happen very often. Also R6 said the staff doesn ' t do a very complete job at bed time either. R6's quarterly Minimum Data Set dated 8/13/13 noted R6 had required extensive assistance to total assist to complete activities of daily living which included grooming. MDS also read that R6 did not have any cognitive impairment. R6's care plan dated 10/31/13 directed staff that R6 required extensive assist of one staff to dress and dependent on staff for grooming needs. During an interview on 10/30/13 at 4:00 p.m. the	F 353		

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F 353	Continued From page 37	F 353		

director of nursing stated that morning cares would include washing of face, under breasts and under arms.

R31 did not receive assistance with toileting as needed.

During an interview on 10/28/13 at 5:36 p.m. R31 stated there were times R31 put call light on 2 or 3 times to get someone to help. On asking why they put it on two or three times R31 stated they felt it depended on the staff that were on because they don ' t always answer the light very quickly. R31 then added that the facility had a lot of " hard residents " (in reference to needing total cares) that would take 2 staff to help. The longest R31 had waited to have the call light answered had been during the evening shift and it took 20 minutes. On answering the call light the staff came in my room and immediately apologized by saying they were having staff trouble and they 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

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F 353	Continued From page 38 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 she felt the facility was short of staff especially during the night. R3 stated 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 as a result. During a second interview on 11/1/13 at 4:40 p.m., R3 stated that last evening she had waited 1 ½ hours to get into the shower. R3 said that the staff told that they would be right in after supper to do the bath so R3 got undressed and "waited and waited." R3 said she was tired of waiting and went to look for the LPN. R3 stated waiting was so frustrating, but this is that kind of place where you wait for help. During an interview on 11/1/13 at 5:30 p.m., the director of nursing and licensed social worker stated they were aware of the short staffing issues, and have discussed it with the quality assessment and assurance committee.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356	**F 356** Kenyon Sunset Home strives to ensure accurate posting of the actual hours worked for nursing staff directly responsible for resident care per shift.	

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F 356	Continued From page 39 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed accurately post the actual hours worked for nursing staff directly responsible for resident care per shift. This had the potential to affect visitors and all 27 residents residing in the facility. Findings include:	F 356	1) Nurse staffing information posting has been identified and revised. 2) Staff has been re-educated on facility expectations regarding the daily posted nursing staff information. 3) Random weekly visual audits will be done. 4) Administrator or designee will monitor for compliance. 5) Completion date: ~~January 14, 2014~~.	December 11, 2013 [initials]

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F 356	Continued From page 40 The posted staff reports for 10/26/13 through 10/31/13 (days of survey) were reviewed with the scheduler. The scheduler indicated the hours posted were incorrect and that on 10/28/13 a RN not a LPN, had worked the over night shift, and that the facility had no bath aid during the day. The scheduler stated that on 10/29/13, the facility had 4 nursing assistants (NA) working, not 3 as indicated for the day shift, for a total of 30.5 hours and not 22.5 hours as posted. The scheduler stated that for 10/30/13 the facility had 4 NAs during day for a total of 30.50 hours, and 4 NA staff on the evening shift for a total of 23.5 hours versus the 22.5 hours total as posted. The scheduler indicated for 10/31/13, the facility had 4 NAs during the day and no bath aid. This made for a total NA staffing of 30 hours, not the posted total of 22.5 hours; and the NA staffing for the evening shift had a total of 23.5 hours and not the total of 22.5 hours. In addition, the posting of 10/26/13 did not indicate RN coverage for the 24 hour period, but identified an overnight RN as an LPN. In addition the 10/26/13 posting listed 5 hours for a bath aid that was not scheduled and 15 hours posted for overnight NA staffing however, only 13 NA hours were scheduled. During an interview on 11/1/13 at 9:20 a.m. the director of nursing indicated the total hours posted needed to reflect the correct hours and that the RN needed to be noted on the staffing.	F 356		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 425	F 425 Kenyon Sunset Home strives to clarify physician order discrepancies. 1) R17 physician's orders have been reviewed and clarified per physician order along with justification of necessity of change. 2) All Kenyon Sunset Home residents' physician's orders have been reviewed and clarified per physician orders along with justification of necessity of change.	

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F 425	Continued From page 41 §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to clarify physician order discrepancies for 1 of 5 residents (R17) reviewed for unnecessary medications. Findings include: R17 lacked reconciliation and physician notification of discrepancies for orders dated 10/14/13 and 8/15/13 orders. The medication dosage had changed yet no indication or justification for the change was found. The physician notes dated 10/14/13 listed current outpatient prescriptions and these were compared to the signed physician orders dated 8/15/13. Novolog 70/30 insulin on 8/15 orders was 35 units in morning and 20 units in evening and on 10/14 orders Novolog 70/30 insulin orders were 85 units in a.m. and 70 units in p.m..	F 425	3) All nursing department staff has been re-educated on facility protocol on transcribing physician orders and ensuring physician justification for necessity of change. 4) Random visual audits will be completed. Director of Nursing will monitor for compliance. 5) Completion date: ~~January 14, 2014.~~	December 11, 2013 KPN

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F 425	Continued From page 42 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 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 insulin.	F 425		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require	F 520	**F 520** Kenyon Sunset Home strives to maintain a quality assessment and assurance committee consisting of the director of 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 develop and implement plans of action related to identified problems within the nursing department related to staffing and care needs.	

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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. 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 11/1/13 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 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 especially with the higher acuity residents currently in the facility. The administrator stated she brought this 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	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. 3) Random weekly visual audits will be done which will include the reorganization of the structure of staffing arrangement. 4) Administrator or designee will monitor for compliance. 5) Completion date: ~~January 14, 2014.~~	December 11, 2013 [illegible initials]

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F 520	Continued From page 44 duties nor action plans developed to address the concern.	F 520		

F5379022

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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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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Kenyon Sunset Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok [initials] 12-13-13 RECEIVED DEC - 5 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

No opportunity to correct 12-11-13 DC:
EXIT: 11-1-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chelsea R. Ugland
TITLE: Acting Administrator
(X6) DATE: 12/5/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245379	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENYON SUNSET HOME	127 GUNDERSON BOULEVARD KENYON, MN 55946

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Kenyon Sunset Home is a 1-story building. The building was constructed at 3 different times. The original building was constructed in 1958 and was determined to be of Type II (111) construction, with partial basement. In 1966, an addition was constructed and was determined to be of Type II(111) construction, with a partial basement. In 1968, an addition was constructed and was determined to be of Type II(111) construction, with a partial basement. Because the original building and the 2 additions met the construction type allowed for existing buildings and the facility was surveyed as one building. The nursing home is separated from both an assisted living facility and The Gunderson House by a 2-hour fire walls with opening protectives consisting of labeled, self-closing, 90-minute fire	K 000		

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

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	245379	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____________	10/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 rated door assemblies. The facility is fully fire sprinkler as of 08/09/2013. The facility has a fire alarm system with full corridor smoke detection in and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 38 beds and had a census of 23 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**K 018** 1) Kenyon Sunset Home will check all corridor doors to ensure they fully close and latch into their frames. Kenyon Sunset Home will purchase necessary equipment to replace and fix doors found to be deficient to ensure they are in compliance and provide safety. 2) Kenyon Sunset Home completed this on December 4, 2013. 3) Director of Maintenance, David Floren, is responsible for correction and monitoring.	

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

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K 018	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has corridor doors that do not latch into their frames in accordance with the requirements of 2000 NFPA 101, Sections 19.3.6.3.2. The deficient practice could affect all 23 residents. FINDINGS INCLUDE: On facility tour between 9:30 AM and 11:30 AM on 10/30/2013, observation revealed that the double kitchen doors (which opens into the corridor) do not positive latch. This deficient practice was confirmed by the Facility Maintenance Director (DF) at the time of discovery.	K 018		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff	K 050	K 050 1) Kenyon Sunset Home will hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. 2) Kenyon Sunset Home will complete the fire drills at least quarterly on each shift and at varying times. 3) Director of Maintenance, David Floren, is responsible for correction, completion, and monitoring.	12/5/13

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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: Day: 1251, 1300, 1000 and 1303 hours Evening: 1405, 1414, 1420 and 2030 hours This deficient practice was confirmed by the Facility Maintenance Director (DF) at the time of discovery.	K 050		
K 071 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens 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.	K 071	**K 071** 1) Kenyon Sunset Home will check facility laundry chute to ensure it automatically shuts and latches. 2) Kenyon Sunset Home will complete this by ~~January 14, 2014.~~ 12-11-13 3) Director of Maintenance, David Floren, is responsible for correction, completion, and monitoring.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 071	Continued From page 5 (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observations, the facility has a laundry chute that does not meet the requirements of Sections 19.5.4, 9.5 and 8.4 and NFPA 82. This deficient practice could affect 23 residents Finding include: On facility tour between 9:30 AM and 11:30 AM on 10/30/2013, observation revealed, that the 1st floor soiled linen chute door that is open to the corridor does automatically shut and latch. This deficient practice was confirmed by the Facility Maintenance Director (DF) at the time of discovery.	K 071	K 147 1) Kenyon Sunset Home will check facility for extension cord use. Extension cords have been removed and six-plex adaptor has been removed. 2) Kenyon Sunset Home completed this on October 30, 2013. 3) Director of Maintenance, David Floren, is responsible for correction, completion, and monitoring.	10-31-13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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

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K 147	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical supply in accordance with the requirements of 2000 NFPA 101 - 9.1.2, 1999 NFPA 70, and 2007 Minnesota State Fire Code 605.4 and 605.5 . The deficient practice could affect 11 out of 23 residents. Findings Include: On facility tour between 9:30 AM and 11:30 AM on 10/30/2013, observation revealed, that the following items were found: 1. 1st floor - Kitchen - rolling cooler is plugged into extension cord 2. 1st floor - Dietary supervisor office a. desk light is plugged into extension cord b. power strip plugged into six-plex adaptor 3. Resident room # 226 - nebulizer plugged into extension cord These deficient practices were confirmed by the Facility Maintenance Director (DF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147		

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,

Chelsea R. Ugland

Chelsea R. Ugland
Acting Administrator
127 Gunderson Blvd.
Kenyon, MN 55946
cugland@kenyonsunsethome.com
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;**

<u>Appeal Rights</u> - 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:

- 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.

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,

- 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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Sincerely,

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

5379s14.rt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00145	A. BUILDING: ______ B. WING ______	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENYON SUNSET HOME	127 GUNDERSON BOULEVARD KENYON, MN 55946

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On October 28, 29, 30 , 31, and November 1, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	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.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENYON SUNSET HOME	127 GUNDERSON BOULEVARD KENYON, MN 55946

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement	2 255		

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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 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 11/1/13 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 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 especially with the higher acuity residents currently in the facility. The administrator stated she brought this 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 duties nor action plans developed to address the concern.

SUGGESTED METHOD OF CORRECTION:
The administrator, director of nursing, medical director and consulting pharmacist, could review and revise the facility's system used to identify quality of care concerns, develop and implement

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2 255	Continued From page 3 action plans to correct the identified quality issues, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME OF CORRECTION: Twenty One (21) days.	2 255		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a resident specific comprehensive care plan for 2 of 4 residents (R3, R36) who were newly admitted to the facility. Findings include: R3 did not have a comprehensive care plan developed 21 days after admission. R3 was admitted on 9/25/2013 with diagnoses	2 555		

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which included: macular degeneration (blindness), high blood pressure, chronic pain, GERD (gastro-esophageal reflux disease), depression, and chronic renal insufficiency stage 3.

A temporary care plan dated 9/25/2013 was provided and it addressed limited mobility related to macular degeneration, bowel and bladder, chronic pain, altered nutrition related to diabetes, cellulitis of left arm and abscess, altered comfort related to chronic pain, falls related to macular degeneration, and potential for medications side effects. It did not address vision, communication, psychosocial wellbeing, activities, or vulnerable adult related to abuse/neglect.

The admission Minimum Data Set dated 10/1/2013 identified the resident's cognitive status as alert and oriented. The functional status of the resident for activities of daily living (ADL) identified as limited assist of one staff except for extensive assist of one staff for dressing, toileting and independent in eating once set up.

On 10/30/2013 at 2:15 p.m., the director of nursing (DON) was interviewed regarding the lack of a comprehensive care plan for R3. According to the DON, R3 did not have a comprehensive care plan; however, R3 did have a temporary care plan.

R36 did not have a comprehensive care plan developed after admission.

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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.

R36's care plan with original date of 10/16/2013 did not include interventions and treatments to address the triggered areas identified on the admission Minimum Data Set (MDS) dated 10/1/13 which included: delirium, cognition, vision, communication, activities of daily living (ADL)s function/rehab potential, bowel and bladder, mood state, falls, nutritional/dehydration, oral/dental care, pressure ulcers/skin, psychotropic drug use, physical restraints, other specific needs/medications used, pain management.

On 10/30/2013 at 12:40 p.m., the licensed social worker verified the care plan provided to the surveyor was computer generated and the most up to date the facility had.

Facility policy dated 3/1/2008 for Admission/Readmission of the Resident Policy and Procedure was reviewed and noted: Under Forms to be completed on admission: 1. Individual Resident care plan should be started on admission. Complete care plan to be completed within 21 days of admission.

SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could provide education for the licensed staff regarding the importance of developing individualized plans related to acitivities of daily living

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2 555	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 555		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate nursing staff to provide resident cares based on the residents assessed need for assistance including but not limited to eating and dining for 6 of 6 residents (R32, R1, R23, R6, R31 and R3) assessed to need assistance with activities of daily living (ADL) needs. This had the potential to affect all 27 residents in the facility. Findings include: R31, R1 and R6 and the other 24 residents were observed during the supper meal on 10/28/13 from 5:35 p.m. to 6:10 p.m. There were eight residents which included R31, R1 and R6 who were assessed to need assistance to eat. There were three nursing assistants (NA) in the dining room and one licensed practical nurse (LPN) was in and out of the dining room and had not assisted any resident with eating. All meals were dished up	2 800		

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and delivered to each resident by 5:49 p.m.

There were two NAs assisting the four residents at a table to eat. R31, R1 and R6 were seated at a different table which was located next to the table the two NAs were assisting resident to eat. R31, R1 and R6 were assessed to need assistance to eat and had been unassisted to eat while their food had been placed in front of them on the table. The fourth resident at the table ate independently while R31, R1 and R6 watched. At 6:00 p.m. which was 11 minutes after the food was placed in front of R31, R1 and R6 NA-B sat at the table and began to help them eat. NA-B was observed to frequently stand and change chairs to help all three eat a few bites of food then move to the next resident repeating this rotation until R31, R1 and R6 had completed eating.

The director of nursing (DON) was interviewed on 10/28/13 at 6:30 p.m. concerning the staffing in the dining room for this meal. DON stated that this would be the " normal " staffing for the shift.

R6 lacked services with personal cares as needed.

During an interview on 10/28/13 at 7:10 p.m. R6 stated have had to wait for 40 minutes to get help when they turn the call light on so they can get to the bathroom timely. On further interview it was learned that R6 had had bowel incontinence while waiting for help. R6 stated doesn't feel good about that.

R6 was observed on 10/30/13 from 8:00 a.m. to 8:30 a.m. while nursing assistant (NA)-E provided morning care. NA-E provided peri-care with a wet washcloth, assisted R6 to get dressed, and then transferred R6 to wheelchair. However, R6

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had not washed or encouraged R6 to wash face, hands, or underarms.

On 10/31/13 at 10:00 a.m. R6 stated would have preferred to be washed up completely in the morning but R6 stated that doesn ' t happen very often. Also R6 said the staff doesn ' t do a very complete job at bed time either.

R6's quarterly Minimum Data Set dated 8/13/13 noted R6 had required extensive assistance to total assist to complete activities of daily living which included grooming. MDS also read that R6 did not have any cognitive impairment. R6's care plan dated 10/31/13 directed staff that R6 required extensive assist of one staff to dress and dependent on staff for grooming needs.

During an interview on 10/30/13 at 4:00 p.m. the director of nursing stated that morning cares would include washing of face, under breasts and under arms.

R31 did not receive assistance with toileting as needed.

During an interview on 10/28/13 at 5:36 p.m. R31 stated there were times R31 put call light on 2 or 3 times to get someone to help. On asking why they put it on two or three times R31 stated they felt it depended on the staff that were on because they don ' t always answer the light very quickly. R31 then added that the facility had a lot of " hard residents " (in reference to needing total cares) that would take 2 staff to help. The longest R31 had waited to have the call light answered had been during the evening shift and it took 20 minutes. On answering the call light the staff came in my room and immediately apologized by saying they were having staff trouble and they

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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 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 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 hours to get into the shower. R3 said that the staff told that they would be right in after supper to do the bath so R3 got

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2 800	Continued From page 10 undressed and "waited and waited." R3 said he was tired of waiting and went to look for the LPN. R3 stated waiting was so frustrating, but this is that kind of place where you wait for help. During an interview on 11/1/13 at 5:30 p.m. the directors of nursing and licensed social worker stated they were aware of the short staffing issues and have discussed it with the quality assessment and assurance committee. SUGGESTED METHOD OF CORRECTION: The director of nursing and administrator could re-evaluate staffing assignments for meal assistance. The director of nursing and administrator could develop and implement a staffing plan that ensured each resident's individualized needs were addressed and met. The director of nursing and administrator could review and revise staffing policies. The director of nursing could develop and implement a system which ensured appropriate supervision of resident meal times. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		

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written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure an effective pain management regimen and comprehensive 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 quarterly Minimum Data Set (MDS) dated 8/6/13 indicated a BIMS (brief intellectual mental

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status) score of 14 to 15 which meant R12 had no cognitive impairment. The MDS identified R12 had constant pain rated as a 6 on a scale of 0 to 10 with 10 as worst pain and received as needed pain (PRN) medications. This has been a change from the 5/7/13 quarterly MDS where R12 had not received PRN pain medications. The 8/6/13 MDS also identified R12 as requiring extensive assist with bed mobility, dressing, and toileting and otherwise was independent. Also R12 used a walker to ambulate.

The Resident Pain Interview form dated 8/6/13 identified R12 as having pain almost constantly in the left hip, had trouble sleeping because of the pain, rated the pain at 6 on a scale of 10, but was unable to identify the intensity of the pain over the past 5 days. The Resident Pain Interview also noted R12 had no scheduled pain medications. This assessment had not identified potential physical, clinical, or environmental risk factors potentially causing R12's pain to determine what interventions both non-pharmacological and medication use to control pain.

Narrative nursing notes dated 8/17/13, 8/27/13 and 10/14/13 identified R12 as having left hip pain. These notes had not assessed the potential factors causing the pain or what non-pharmacological and pain medication interventions were utilized to manage pain.

R12 ' s care plan dated 10/31/13 identified a problem of pain management including chronic pain in left hip. The approaches included administer scheduled/PRN pain medications (although R12 had no scheduled pain medications at this time), pain assessment quarterly, update the doctor, call light in reach, monitor for effectiveness of pain medication,

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encourage mobility, offer non-pharmacological measure for pain relief (there was not specific non-pharmacological interventions identified such as ice, heat, message, movement, etc.)

The director of nursing (DON) was interviewed on 11/1/13 at 8:45 a.m. and indicated R12 was able to tell the staff when having pain. DON stated R12 would isolate self in their room after family visits or due to being "Just too darn sore" in reference to hip pain. DON verified no scheduled pain medication had been attempted only PRN. On 11/1/13 at 3:45 p.m. the licensed social worker and RN-B indicated they had not completed a pain assessment to evaluate if uncontrolled pain management had contributed to R26 ' s depression and excess sleep.

Based on observation, interview and document review, the facility failed to ensure assistance with personal hygiene was provided for 1 of 1 resident (R6) observed during mourning cares.

Findings include: R6 did not receive assistance with morning personal cares.

R6 was observed on 10/30/13 from 8:00 a.m.to 8:30 a.m. while nursing assistant (NA)-E provided morning cares to help R6 get ready for breakfast. NA-E obtained a wet washcloth from the bathroom and provided peri-care to the resident. NA-E stated R6 was not able to use the peri wet wipes independently. NA-E then positioned and fastened an incontinent brief, rolled R6 in bed to put slacks on and then proceeded to put R6's socks and slippers on. With assistance from a second NA, R6 was transferred from bed to the wheelchair using the mechanical lift. NA-E then assisted to dress the upper portion of R6 ' s body, handed R6 dentures and left the room and did not

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return to assist R6 to wash her face, hands, or underarms.

On 10/31/13 at 10:00 a.m. R6 stated they preferred to be washed up in the morning with soap and water. R6 then stated the staff doesn ' t always have time to wash her body with mourning cares and sometimes not at bed time either.

R6's quarterly Minimum Data Set dated 8/13/13 noted R6 required extensive assist to total assistance for completing activities of daily living such as bathing and personal cares also had no cognitive impairment. R6's care plan dated 10/31/13 directed staff that R6 required extensive assist of one staff to dress and dependent on staff for grooming needs.

During an interview on 10/31/13 at 9:45 a.m. about what morning cares were to be done for the resident, NA-F stated that morning cares consisted of washing face, hands, under arms, and under breasts. NA-F stated R6 would usually allow staff to do this when morning cares were done.

The facility provided an undated policy entitle A.M. Cares that read, "6. Wash resident's face, hands and underarms and dry well."

During an interview on 10/30/13 at 4:00 p.m. the director of nursing stated that morning cares would include washing of face, under breasts and under arms.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee could develop policies and procedures to ensure residents consistently provided the appropriate interventions. The director of nursing or

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2 830	Continued From page 15 designee could educate all appropriate staff on these policies and procedures. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21410	MN Rule 4658.0815 Subp. 1 Employee Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Information bulletin 09-02 Tuberculosis Prevention and Control: Nursing Home. Minnesota Rule 4658.0815 Subpart 1 Employee Tuberculosis Program is waived. Conditions of Wavier: - Follow the U. S. Centers for Disease Control and Prevention ' s "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005," Morbidity and Mortality Weekly Report (MMWR) 2005;54 (No. RR-17), and as subsequently amended, for infection control procedures and requirements ("CDC Guidelines"). Refer to this document for complete definitions of terms. - Assign administrative responsibility for the TB infection control program to appropriate personnel. Administrative responsibilities include the establishment of an infection control team (one or more individuals), completion (and periodic update) of a written TB risk assessment, development (and periodic review) of a written TB infection control plan, and screening of health care workers (HCWs) for TB as discussed below.	21410		

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- Conduct a problem evaluation if a case of suspected or confirmed TB disease is not promptly recognized and appropriate measures are not taken.

- Perform an investigation in collaboration with the local health department if health-care-associated transmission of M. tuberculosis is suspected.

This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to complete a Tuberculosis (TB) risk assessment according to the current Centers for Disease Control (CDC) guidelines for preventing the transmission of Tuberculosis this had the potential to affect all residents in the facility.

Findings include:

A Tuberculosis Risk Assessment completed by the facility was not found nor provided.
On 10/31/13 at 3:30 p.m. the director of nursing indicated she was unable to find a TB risk assessment, but will start one as of today. The director of nursing stated the policy stated a TB risk assessment was to be completed annually.

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She felt the facility was at low risk.
SUGGESTED METHOD OF CORRECTION:
The director of nursing could ensure that the Tuberculosis Risk Assessment was completed annually.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

21415 MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program — 21415

Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived.

Conditions of Waiver:

- All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB).

- All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility 's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414.

· HCWs with abnormal TB screening results must receive follow-up medical evaluation

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according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb

· All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file.

· All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure employee tuberculin skin tests (TST) were read within 48 to 72 hours of administration for 7 of 9 employee (E-M, E-N, E-O, E-P, E-Q, E-R and E-S) TST forms reviewed.
Findings include:
E-M hired 8/21/13 received step one of TST on 8/21/13 and did not have the TST read.
E-N hired 10/15/13, received step one of TST 12/18/12 and had the TST read 1/22/13 (greater than 72 hours after administration.)
E-O was hired 10/14/13, received step one of TST 10-/14/13 and had the TST read 10/18/13 (greater than 72 hours after administration.)

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21415	Continued From page 19 E-P was hired 9/25/13 and received step one of TST 9/27/13 and did not have the TST read. E-Q received the TST on 2/4/13 and had the TST read on 2/25/13 (greater than 72 hours after administration.) E-R received the TST on 10/8/12 and had the TST read on 10/12/12 (greater than 72 hours after administration) E-S received the TST on 10/3/12 and had the TST read on 10/8/12 (greater than 72 hours after administration.) The facility provided a procedure entitled Minnesota Department of Health The TB Skin Test (Mantoux). The procedure read, "Your health care provider must check your arm 2 or 3 days after the TB skin test." The facility's policies entitled Mantoux Health Record for Employee (undated), TB Control Plan (dated 3/1/10), Tuberculosis Screening Record (undated), Tuberculosis (4/19/11), and Tuberculin Test (Mantoux) - (undated) were provided by the facility. Review of these policies did not provide guidelines related to reading of the TST. During an interview on 10/31/13 at 10:15 a.m. the director of nursing stated the Mantoux test was to be read within 48-72 hours after being given. SUGGESTED METHOD OF CORRECTION: The director of nursing could ensure the infection control person complete the Tuberculosis Skin Test monitoring and reading for all employees receiving the TST in the recommended 48 to 72 hours after receiving the medication. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21415		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring	21540		

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21540	Continued From page 20 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure as needed (PRN) pain medication and antianxiety medications were monitored for effectiveness for 1 of 5 residents (R26) reviewed for unnecessary drugs and the facility failed to administer the antianxiety medication as directed in the care plan protocol for 1 of 5 residents (R26) reviewed for unnecessary drugs. Findings include: R26 received PRN Roxanol (is a morphine medication used to treat moderate to severe pain) and Ativan (antianxiety medication) without consistent monitoring of effectiveness of	21540		

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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.

R26's care plan identified a problem of psychotropic drug use and listed behaviors as refusal of peri-cares after incontinence episode, yelling out at staff and other residents. The interventions for these behaviors were to give medications as ordered; rule out pain by offering and administering Roxanol when anxious or agitated. If no decrease in behaviors in 30 minutes, then give PRN Ativan.

The medication administration records (MAR) were reviewed for August 2013 through October 2013. August ' s MAR showed R26 received Roxanol 5 times and Ativan 12 times. The Roxanol was given prior to the Ativan only twice out of 12 opportunities. In September the MAR showed R26 received Roxanol 5 times and Ativan 19 times and the Roxanol had been given only once out of 19 opportunities. In October the MAR showed R26 received Roxanol 1 time and Ativan 8 times and the Roxanol had been given 0 times out of 8 opportunities.

The nursing documentation for August 1, 2013 through October 29, 2013 had been reviewed.

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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.

The director of nursing (DON) was interviewed on 11/1/13 at 8:40 a.m. DON stated staff was not following through with the PRN directions as outlined on the care plan or documentation the PRN usage.

SUGGESTED METHOD OF CORRECTION:
The director of nursing and consultant pharmacist could inservice licensed staff on the need for medication monitoring. The director of nursing and consultant pharmacist could review and review policies to ensure medications were monitored. The director of nursing could monitor staff compliance.

TIME PERIOD FOR CORRECTION: Twenty One (21) days.

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21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults	21990		

Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to immediately report to the administrator, immediately report to the designated State agency, complete a thorough investigation and failed to protect 3 of 5 residents (R31, R3 and R6) reviewed for abuse/neglect allegations. R3 reported being afraid of a nursing assistant after hearing the nursing assistant speak harshly to a neighboring resident (identified as R31) during morning cares. Even though this allegation of abuse was reported to facility staff following the incident, the facility did not immediately act upon the report and did not protect R31 or R3 from further potential abuse. During this time the identified nursing assistant

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(NA)-E continued to work with these residents for several more days before the survey agency brought this to the facility's attention, at which time NA-E had been suspended from work while an investigation was conducted. The findings resulted in an Immediate Jeopardy (IJ)situation for 1 of 5 residents (R3) reviewed for allegations of abuse. In addition, all other residents remained at risk of potential harm, verbal abuse, that is not immediate jeopardy, as NA-E had the potential to work unsupervised with all residents in the facility.

The immediate jeopardy began on 10/26/13, when a licensed practical nurse (LPN)-A was made aware of an allegation of abuse and failed to internally report, investigate, report to the designated State agency (Office of Health Facility Complaints-OHFC), and protect the involved residents. Consequently, the alleged perpetrator (NA-E) continued working with the residents for several days. The administrator, director of nursing, and licensed social worker (LSW) were notified of the immediate jeopardy on 10/30/13 at 5:20 p.m. The immediate jeopardy was removed on 10/31/13 at 4:30 p.m. however, noncompliance remained at the lower scope and severity level of an F-a pattern, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

Findings include: R3 was interviewed on 10/28/13 at 2:54 p.m. During the interview, R3 was asked whether or not she or anyone else in the facility had been abused. R3 had immediately responded, "Yes" to the question and on further interview with R3 it was learned that R3 had overheard a conversation between a NA-E and R31 who lived next door to her. R3 went on to say that NA-E told R31 to get her own blouse on and

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if she didn't, the staff would come back and GET IT ON FOR HER in a loud and threatening tone of voice. R3 said she'd also heard NA-E call R31 "lazy." NA-E had completed cares for R31 and went into R3's room at which time R3 stated that NA-E "was at me." R3 stated NA-E had entered her bedroom and had stated, in a sarcastic and threatening tone, "This is the third time I have been in here!" R3 said NA-E had made that comment after R3 had requested more washcloths since she had used her last one. R3 said that because of 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 didn't mention my back. She [NA-E] was so angry and she [NA-E] went out of here storming. I don't know why she was so angry." R3 stated she had spoken to licensed practical nurse (LPN)-A about her concerns on 10/26/13 but nothing had been done. R3 then stated her daughter family (F) member-A had stopped in to see her today and added, "They [reference to the director of nursing (DON) and licensed practical nurse (LPN)-B] are on it today. The boss [reference to DON] came down here and talked to me and my daughter (F-A) was here and heard the story. I didn't like to be a tattle tale but I didn't like the action she [NA-E] took. I tried hard to dress faster, but I can't put on my arm thing and elastic stockings myself." R3 indicated that because of the way NA-E was acting, she had tried to dress faster on Saturday so she would not upset NA-E when she came in to help her with her care.

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

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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. The DON stated that R3 kept repeating that NA-E was angry and that NA-E had torn the privacy curtain in R3's room. The DON stated she had spoken with NA-E yesterday (10/29/13) after having met with R3 and her family, and had informed NA-E her behavior had been tormenting and belittling to R31 and R3. The DON confirmed

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she had not documented the alleged abuse reported by R3 nor had she documented the interview with NA-E. The DON verified that neither she nor LPN-B had immediately informed the administrator or the State agency about the allegations. In addition, the DON verified there had been no interventions put in place to protect R3 and R31 from potential ongoing abuse by NA-E, and that NA-E had been allowed to continue working un-supervised, caring for these two residents and others in the facility. The DON verified that she was new to her position at the facility, and had not felt R3's allegation met the criteria for reporting.

During an interview on 10/30/13 at 1:35 p.m., the licensed social worker (LSW) stated she was unaware of the alleged abuse R3 had reported to LPN-A, LPN-B and the DON. After interviewing the LSW, the LSW went to speak to the DON. At 1:40 p.m., the LSW approached the surveyor and stated the DON had "addressed the situation." The LSW verified there was no documented record of the alleged 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 had received two previous warnings in the past related to rough and rude behavior toward residents. The LSW also stated she was responsible for staff training regarding issues 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

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KENYON SUNSET HOME	**127 GUNDERSON BOULEVARD KENYON, MN 55946**

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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 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

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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 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.

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

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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 weren't always enough staff to answer her call light, and that she had to wait for long periods of time for staff assistance with care including assistance to the toilet.

The administrator, LSW and DON were interviewed as a group on 10/30/13 at 4:30 p.m. The administrator and LSW again stated they had been unaware of the alleged allegation of abuse reported by R3 until the surveyors had brought it to their attention. The DON verified she had not reported the allegation of abuse immediately to the administrator or to OHFC when she had first become aware of R3's allegation on 10/28/13. The LSW and DON verified that no one had

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initiated a thorough investigation of the allegation of abuse reported by R3, such as interviewing R31, other residents, and staff. It was not until after this issue was brought to the attention of the administrative staff on 10/30/13, that interventions were implemented to protect R31 and R3 from further potential abuse while an investigation was conducted, and the incident was reported to the State agency late on 10/30/13.

R6 had complaints of rough treatment provided by staff and had reported this to other staff, but said nothing had been done about it. On further investigation the report of alleged allegation of abuse had not been immediately reported to the administrator, OHFC nor an investigation completed.

Record review indicated R6 had a BIMS assessment conducted on 8/13/13, that identified a score of 15 indicating the resident had not cognitive impairment. The quarterly MDS dated 8/13/13, indicated the resident required extensive assistance from staff with all ADLs.

During an interview on 10/28/13 at 6:46 p.m., R6 stated that staff would "Roughly roll" them into the bed rail while dressing. R6 stated that the case manager had been told about it and that the case manager said she had talked to staff about the rough treatment, but R6 stated she continued to have trouble with being rolled into the side rail.

R6 was observed during morning cares on 10/30/13 from 8:00 am to 8:30 a.m. Cares were provided by NA-E. R6 was observed lying in a large bed with side rails in the up position. NA-E rolled R6 from side to side four times, and provided cares. No concerns with NA-E rolling R6 roughly into the rails was observed.

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During an interview on 10/30/13 at 4:55 p.m. R6 was again questioned about her concerns about rough treatment. R6 explained that staff would help roll her from side to side, and then press down too hard using the sides of their hands to keep R6 from rolling back. R6 stated she would have red marks on her hands from staff being too rough. R6 stated she had reported this rough handling to the nurse "more than once," and it seemed like nothing had been done about it as the rough treatment continued. R6 was asked by this surveyor if she could identify which staff 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-A.

During an interview on 10/31/13 at 9:45 a.m. LPN-A 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.

The facility's Vulnerable Adult/Abuse Prevention Policy revised 7/8/13, included "It is the right of

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each individual resident to be free from verbal, sexual, physical and mental abuse..." Under 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 immediately if: i. One has knowledge of maltreatment/neglect of a resident..." Under How to report a suspected incident of abuse/neglect, the policy read, "Report all alleged violations and substantiated incidents to the administrator and in his/her absence contact the designated in charge 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 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

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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 administrator 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 immediately with the staff currently working then the managers were directed to call all other employees; education was to be documented to include that the employee was contacted, and acknowledged an understanding of the policies. Implementation of this plan was verified by review of policies and interview of staff. The immediate jeopardy was removed on 10/31/13 at 4:30 p.m. however, noncompliance remained at the lower scope and severity level of an F (corresponds to a pattern on the scope and severity grid used by nursing home determination of compliance) , which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

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21990	Continued From page 35 SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise the facility Abuse Prevention Policy related to timing of reporting of potential resident maltreatment. The administrator of designee could educate staff related to the policy and monitor to assure the facility reported potential resident maltreatment timely. TIME PERIOD FOR CORRECTION: One (1) day.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable	22000		

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adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the facility failed to implement their Abuse Prevention Policy which indicated allegations of abuse were to be immediately reported to the administrator, reported to the State agency, failed to initiate an investigation, and failed to implement measures to protect residents involved 3 of 3 residents (R3, R31, R6) who were reviewed for allegations of abuse. This deficient had the potential to affect all 27 residents residing in the facility who were vulnerable to abuse due to staff failure to implement their policies.

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Findings include: 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 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 immediately if: i. One has knowledge of maltreatment/neglect of a resident..." Under How to report a suspected incident of abuse/neglect, the policy read, "Report all alleged violations and substantiated incidents to the administrator and in his/her absence contact the designated in charge 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 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

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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."

R3 was interviewed on 10/28/13 at 2:54 p.m. During the interview, R3 was asked whether or not she or anyone else in the facility had been abused. R3 had immediately responded, "Yes" to the question and on further interview with R3 it was learned that R3 had overheard a conversation between a NA-E and R31 who lived next door to her. R3 went on to say that NA-E told R31 to get her own blouse on and if she didn't, the staff would come back and GET IT ON FOR HER in a loud and threatening tone of voice. R3 said she'd also heard NA-E call R31 "lazy." NA-E had completed cares for R31 and went into R3's room at which time R3 stated that NA-E "was at me." R3 stated NA-E had entered her bedroom and had stated, in a sarcastic and threatening tone, "This is the third time I have been in here!" R3 said NA-E had made that comment after R3 had requested more washcloths since she had used her last one. R3 said that because of 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 didn't mention my back. She [NA-E] was so angry and she [NA-E] went out of here storming. I don't know why she was so angry." R3 stated she had spoken to licensed practical nurse (LPN)-A about her concerns on 10/26/13 but nothing had been done. R3 then stated her daughter family (F) member-A had stopped in to see her today and added, "They [reference to the director of nursing (DON) and licensed practical nurse (LPN)-B] are on it today. The boss [reference to DON] came down here and talked to me and my daughter (F-A) was here

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and heard the story. I didn't like to be a tattle tale but I didn't like the action she [NA-E] took. I tried hard to dress faster, but I can't put on my arm thing and elastic stockings myself." R3 indicated that because of the way NA-E was acting, she had tried to dress faster on Saturday so she would not upset NA-E when she came in to help her with her care.

R3's record was revived. 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

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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. The DON stated that R3 kept repeating that NA-E was angry and that NA-E had torn the privacy curtain in R3's room. The DON stated she had spoken with NA-E yesterday (10/29/13) after having met with R3 and her family, and had informed NA-E her behavior had been tormenting and belittling to R31 and R3. The DON confirmed she had not documented the alleged abuse reported by R3 nor had she documented the interview with NA-E. The DON verified that neither she nor LPN-B had immediately informed the administrator or the State agency about the allegations. In addition, the DON verified there had been no interventions put in place to protect R3 and R31 from potential ongoing abuse by NA-E, and that NA-E had been allowed to continue working un-supervised, caring for these two residents and others in the facility. The DON verified that she was new to her position at the facility, and had not felt R3's allegation met the criteria for reporting.

During an interview on 10/30/13 at 1:35 p.m., the licensed social worker (LSW) stated she was unaware of the alleged abuse R3 had reported to LPN-A, LPN-B and the DON. After interviewing the LSW, the LSW went to speak to the DON. At 1:40 p.m., the LSW approached the surveyor and stated the DON had "addressed the situation." The LSW verified there was no documented record of the alleged incident, nor documentation to indicate how the DON had addressed the

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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 had received two previous warnings in the past related to rough and rude behavior toward residents. The LSW also stated she was responsible for staff training regarding issues 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

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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 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

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not think R3's complaints met the criteria for reporting.

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 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

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weren't always enough staff to answer her call light, and that she had to wait for long periods of time for staff assistance with care including assistance to the toilet.

The administrator, LSW and DON were interviewed as a group on 10/30/13 at 4:30 p.m. The administrator and LSW again stated they had been unaware of the alleged allegation of abuse reported by R3 until the surveyors had brought it to their attention. The DON verified she had not reported the allegation of abuse immediately to the administrator or to OHFC when she had first become aware of R3's allegation on 10/28/13. The LSW and DON verified that no one had initiated a thorough investigation of the allegation of abuse reported by R3, such as interviewing R31, other residents, and staff. It was not until after this issue was brought to the attention of the administrative staff on 10/30/13, that interventions were implemented to protect R31 and R3 from further potential abuse while an investigation was conducted, and the incident was reported to the State agency late on 10/30/13.

R6 had complaints of rough treatment provided by staff and had reported this to other staff, but said nothing had been done about it. On further investigation the report of alleged allegation of abuse had not been immediately reported to the administrator, OHFC nor an investigation completed.

Record review indicated R6 had a BIMS assessment conducted on 8/13/13, that identified a score of 15 indicating the resident had not cognitive impairment. The quarterly MDS dated 8/13/13, indicated the resident required extensive assistance from staff with all ADLs.

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During an interview on 10/28/13 at 6:46 p.m., R6 stated that staff would "Roughly roll" them into the bed rail while dressing. R6 stated that the case manager had been told about it and that the case manager said she had talked to staff about the rough treatment, but R6 stated she continued to have trouble with being rolled into the side rail.

R6 was observed during morning cares on 10/30/13 from 8:00 am to 8:30 a.m. Cares were provided by NA-E. R6 was observed lying in a large bed with side rails in the up position. NA-E rolled R6 from side to side four times, and provided cares. No concerns with NA-E rolling R6 roughly into the rails was observed.

During an interview on 10/30/13 at 4:55 p.m. R6 was again questioned about her concerns about rough treatment. R6 explained that staff would help roll her from side to side, and then press down too hard using the sides of their hands to keep R6 from rolling back. R6 stated she would have red marks on her hands from staff being too rough. R6 stated she had reported this rough handling to the nurse "more than once," and it seemed like nothing had been done about it as the rough treatment continued. R6 was asked by this surveyor if she could identify which staff 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

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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 stated the reporting directions were available at the nursing station for all staff to use. The administrator verified she was not aware that she had to be immediately notified regarding allegations of abuse.

SUGGESTED METHOD FOR CORRECTION: The Director of Nurses and/ or the Social Worker could provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s) policy.

TIME PERIOD FOR CORRECTION: Seven (7) days.