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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XUFL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **02/06/2017** (L34)

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

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	

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

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

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (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
	30			
(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):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 04/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/20/2017 (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)

25. LTC EXTENSION DATE: (L27)

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

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

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245379

April 14, 2017

Ms. Chelsea Kalal, Administrator
Kenyon Sunset Home
127 Gunderson Boulevard
Kenyon, MN 55946

Dear Ms. Kalal:

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 January 27, 2017 the above facility is certified for:

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 1, 2017

Ms. Chelsea Kalal, Administrator
Kenyon Sunset Home
127 Gunderson Boulevard
Kenyon, MN 55946

RE: Project Number S5379026

Dear Ms. Kalal:

On January 9, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 21, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 6, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 30, 2017 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 a standard survey, completed on December 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 27, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 21, 2016, effective January 27, 2017 and therefore remedies outlined in our letter to you dated January 9, 2017, will not be imposed.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245379 Y1	A. Building B. Wing Y2	2/6/2017 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0278	Correction	ID Prefix F0279	Correction	ID Prefix F0280	Correction
Reg. # 483.20(g)-(j)	Completed	Reg. # 483.20(d);483.21(b)(1)	Completed	Reg. # 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2)	Completed
LSC	01/27/2017	LSC	01/27/2017	LSC	01/27/2017
ID Prefix F0282	Correction	ID Prefix F0311	Correction	ID Prefix F0323	Correction
Reg. # 483.21(b)(3)(ii)	Completed	Reg. # 483.24(a)(1)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed
LSC	01/27/2017	LSC	01/27/2017	LSC	01/27/2017
ID Prefix F0329	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.45(d)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	01/27/2017	LSC	01/27/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GN/kfd	3/1/2017	10160	2/6/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/21/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245379 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/30/2017 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0200	01/12/2017	LSC K0211	01/11/2017	LSC K0222	01/11/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	01/11/2017	LSC K0293	01/11/2017	LSC K0345	01/11/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0354	01/16/2017	LSC K0372	01/27/2017	LSC K0712	01/11/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	3/1/2017	37008	1/30/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/21/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XUFL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **12/21/2016** (L34)

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

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	

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

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

12.Total Facility Beds **30** (L18)

13.Total Certified Beds **30** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X 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
	30			
(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):

17. SURVEYOR SIGNATURE Date :
Hamersma, Vicky, HFE NE II 01/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/31/2017 (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)

25. LTC EXTENSION DATE: (L27)

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

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

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 9, 2017

Ms. Chelsea Kalal, Administrator
Kenyon Sunset Home
127 Gunderson Boulevard
Kenyon, MN 55946

RE: Project Number S5379026

Dear Ms. Kalal:

On December 21, 2016, a standard 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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.

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
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 30, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 30, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC 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 ePoC 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. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 21, 2017 (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 June 21, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	12/21/2016

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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278		1/27/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/19/2017

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.

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 _____	12/21/2016

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 278	Continued From page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to identify broken teeth for an oral assessment for 1 of 3 residents (R26) reviewed for dental services. Findings include: R26's annual Minimum Data Set (MDS) dated 10/4/16, had identified for oral/dental status no oral concerns were present. R26's Admission Record, dated 12/21/16, identified diagnosis of hypertension and dementia. During observation on 12/19/16, at 6:37 p.m., surveyor viewed R26's teeth and noted R26 had broken teeth. During observation on 12/20/16, at 2:35 p.m., the director of nursing (DON) verified R26 had broken teeth. The DON confirmed R26's annual MDS dated 10/4/16 failed to identify R26 had broken teeth.	F 278	Kenyon Sunset Home strives to ensure each resident receives & the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing, in accordance with comprehensive assessments and plan of care. 1) A new, accurate oral assessment has been completed for R26 2) All residents living at Kenyon Sunset Home have the potential to be affected by the same deficient practice. 3) The Kenyon Sunset Home assessment policy has been reviewed and updated. A clear schedule has been revised for timing and expectations for completing resident assessments. Kenyon Sunset Home RN staff have be re-educated on the timing and completion of required assessments. 4) The DON or designee will perform weekly audits on completion of oral assessments per schedule. The audits will be completed for a 6 month duration and	

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 _____	12/21/2016

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 278	Continued From page 2	F 278	as needed thereafter for completion. 5) Completion date: January 27,2017	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 279		1/27/17

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 _____	12/21/2016

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 279	Continued From page 3 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for 1 of 3 residents (R19) related to broken teeth, who was reviewed for dental status. Findings include: R19's admission Minimum Data Set (MDS) dated 7/15/16, had identified for oral/dental status broken natural teeth. R19's Admission Record, dated 12/21/16, identified diagnosis of congestive heart failure, diabetes and dementia.	F 279	Kenyon Sunset Home strives to ensure each resident receives care according to comprehensive assessments and an individualized, person-centered plan of care that includes measurable objectives and timeframes to meet each resident□s medical, nursing and mental and psychosocial needs. 1) R19□s care plan has been reviewed and updated with information including his broken teeth. 2) All Kenyon Sunset Home residents	

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 _____	12/21/2016

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 279	Continued From page 4 R19's care plan, dated 10/24/16, indicated R19 required assistance of one with oral hygiene related to cognition. Resident has his own teeth and oral care assist of one twice a day. Assess condition of oral cavity, teeth, tongue, lips. Attempt more frequent oral care if there is halitosis, bleeding or swollen gums. Encourage resident to consume enough fluids to keep mouth moist. Obtain dental consult if requested per family and resident. Provide one assistance for oral hygiene. During observation on 12/19/16, at 5:19 p.m., surveyor viewed R19's teeth and noted R19 had broken teeth on the bottom gum line. During observation on 12/20/16, at 2:23 p.m., the director of nursing (DON) verified R19 had broken teeth. The DON verified R19's admission MDS identified R19 had broken natural teeth. The DON confirmed R19's care plan failed to identify R19 had broken natural teeth. The DON stated broken teeth should be care planned. The facility policy Resident Care Plan, dated revision 1/15/15, indicated it is the policy of the facility to provide clear communication to staff regarding problems, needs and strengths of residents and how to properly care for them and follow the care plan.	F 279	have the potential to be affected by the same deficient practice. 3) Facility IDT staff will review care plans weekly, according to MDS schedule. Temporary care plans are completed upon admission and comprehensive care plans are written by 21 days of admission. Care plans are updated per MDS schedule and within 72 hours of any changes. Nurse Manager, DON, MDS nurse and Care Planning nurse are all responsible to update the care plan for any changes. 4) The DON or designee will review care plans for completion and accuracy twice weekly for duration of 6 months and as needed thereafter for completion. 6) Completion date: January 27,2017	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 280		1/27/17

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 _____	12/21/2016

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 280	Continued From page 5 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-	F 280		

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 _____	12/21/2016

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 280	Continued From page 6 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plan related to elopement risk for 1 of 3 residents (R19) reviewed for accidents; failed to revise the	F 280	Kenyon Sunset Home strives to ensure each resident receives care according to comprehensive assessments and an individualized, person-centered plan of	

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 _____	12/21/2016

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 280	Continued From page 7 care plan for 1 of 5 residents (R26) related to the use of prescribed medications for behaviors and failed to revise care plan with new falls intervetions for 1 of 1 resident (R32) reviewed for falls. Findings include: R19's admission Minimum Data Set (MDS) dated 7/15/16, identified behavior wandering occurred one to three days and a quarterly MDS dated 10/11/16, behavior wandering not present. R19's Admission Record, dated 12/21/16, identified diagnosis of dementia. R19's facility Elopement Risk Observation report, dated 11/9/16, indicated resident is at low risk for elopement, will remove wander guard. R19's resident progress notes, dated 11/9/16, identified wander guard removed. Resident is low risk for elopement. He has made no attempts to leave the unit since July. Observation on 12/20/16, at 12:38 p.m., revealed R19 was sitting in his wheelchair in his room and no wander guard was observed to be seen in place on R19's wheelchair or body. R19's care plan, dated 10/24/16, indicated resident had wandered to assisted living where he lived wondering where his residence was. Avoid over-stimulation (noise, crowding, other physically aggressive residents). Check daily that placement is under seat on the middle brace, the day shift. Equip resident with a device that alarms when wanders. Check for proper functioning of device every 1st Wednesday of the month. Label resident's belongings and environment to	F 280	care that includes measurable objectives and timeframes to meet each resident□s medical, nursing and mental and psychosocial needs. 1) A. The care plan for R19 has been updated regarding his wander guard. B. The care plan for R26 has been updated with specific behavior monitoring for his Zoloft, the specific target behaviors associated with his Seroquel and the specific symptoms and interventions associated with his Depakote. C. The care plan for R32 has been updated fall interventions since her fall on 12/16/16. 2) All Kenyon Sunset Home residents have the potential to be affected by the same deficient practice. 3) The resident care plan policy has been reviewed and updated. Facility IDT staff will review care plans weekly, according to MDS schedule. Temporary care plans are completed upon admission and comprehensive care plans are written by 21 days of admission, updated per MDS schedule and within 72 hours of any changes. Nurse Manager, DON, MDS nurse and Care Planning nurse are all responsible to update the care plan for any changes. To include resident participation in care planning his/her care plan will be reviewed and signed during care conferences. 4) The DON or designee will audit care plans for completion weekly for a 6 month duration and prn thereafter for completion. 5) Completion date: January 27,2017	

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 _____	12/21/2016

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 280	Continued From page 8	F 280		

promote recognition. Maintain a calm environment and approach to the resident. Provide care, activities, and a daily schedule that resembles the resident's prior lifestyle. Remove resident from other resident's rooms and unsafe situations. When resident begins to wander, provide comfort measures for basic needs (pain, hunger, toileting, too hot/cold).

R19's care plan failed to be revised after the discontinuation of the wander guard.

On 12/20/16, at 2:45 p.m., the director of nursing (DON) confirmed R19's care plan had not been revised after the wander guard had been discontinued. The DON stated one nurse was responsible for the care plans and the nurse responsible worked one day per week. The DON stated information regarding changes for care plans or when the MDS was completed are placed in a basket for the nurse to update the care plans.

R26's physician orders dated 9/16/16, identified an order for Divalproex (a medication used for behaviors) 125 mg (milligrams) three times a day for dementia with behavioral disturbance, dated 10/4/16, Zoloft (antidepressant) 50 mg every a.m. for depression, and dated 12/8/16, Seroquel 12.5 mg twice daily with increase to 25 mg twice daily on 12/19/16 for dementia with behavioral disturbances.
R26's behavior sheets dated 12/16, identified behavior:1. upset/agitated with interventions of 1:1 visit, snack, redirect, call family for translation. 2. sexual behaviors - flirting with staff with interventions of redirect, re-approach and offer choices.
R26's care plan dated 10/19/16, included

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 _____	12/21/2016

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 280	Continued From page 9	F 280		

psychotropic drug use problem: resident is at risk for adverse consequences related to receiving Depakote, Zoloft and trazadone medication for treatment of Dementia with behavior issues and insomnia. Resident started on Zoloft and Depakote increased due to increased signs and symptoms of depression and behaviors. Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms. Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Attempt GDR without affecting results. Document how well resident sleeps. Give trazadone a half hour before bedtime. Monitor for increase in anxiety or depression. Pharmacy consult per routine. Quantitatively and objectively document the resident's mood. TD (Tardive Dyskinesia) assessments quarterly. Valporic labs per physician orders and report abnormal findings.
R26's care plan/behavior sheets failed to identify what specific symptoms were associated with the prescribed Zoloft for the diagnosis of depression, what specific target behaviors were associated with the prescribed Seroquel for diagnosis of paranoia, what specific symptoms were associated with the prescribed Depakote for diagnosis of dementia with behavioral disturbances and specific interventions related to the use of the medications.
R32's Nursing progress note date 12/16/16 indicated that she had a fall on 12/16/16 with injury at 4:30 a.m., R32 had been observed sitting on the floor in front of her recliner chair. Facility completed assessment of fall and resident. Nursing progress note date 12/16/16 at 1:34 p.m. indicated. Facility received orders for x-ray, and x-ray report dated 12/16/16 indicated positive for

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 _____	12/21/2016

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 280	Continued From page 10	F 280		

fracture of left wrist. Nursing progress note 10:00 p.m. on 12/16/16 indicated the on call medical doctor (MD) updated and received orders for: ice and to elevate left wrist and to use splint and have R32 seen on Monday 12/19/16. 12/19/16 nursing progress note stated that R32 returned from MD Appointment with orders to continue splint, Tylenol for pain and portable professional x-ray for healing in 6 weeks.

On 12/21/16 at 9:00 a.m. staff was asked for information regarding R32's fall on 12/16/16. Received a hand written note with interdisciplinary team (IDT), IDT's intervention for fall on 9/21/16 included low bed, ensure call light is to her center or to her right on her body. On physical therapy/occupation therapy (PT/OT) 5/wk. which are included in care plan, revised on 12/05/16. Interventions for 12/16/16 included: on PT/OT, every 1 hour checks on nights, certified nurse practitioner to evaluate as needed trazadone order on next visit (12/22/16) due to last 2 falls on nights, Therapy focusing on sit to stand and working on getting in and out of bed to promote sleeping in bed as opposed to recliner. Also the use of splint to left wrist was discontinued on 12/05/16 and not revised since fall on 12/16/16, which was reinstated by on-call physician on 12/16/16 and continued when R32 was seen in clinic on 12/19/16.

R32's care plan edited on 12/5/16, indicated that R32 is a fall risk related to history of falling and recent hip fracture, incontinence, assistance needed for mobility and recent stroke. However, there had not been any updated fall interventions since R32's fall dated 12/16/16. Which included: on PT/OT, every 1 hour checks on nights, certified nurse practitioner to evaluate as needed

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 _____	12/21/2016

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 280	Continued From page 11 trazadone order on next visit (12/22/16) due to last 2 falls on nights; Therapy focusing on sit to stand and working on getting in and out of bed to promote sleeping in bed as opposed to recliner. Also the use of splint was discontinued on 12/05/16 and not revised since fall on 12/16/16. During interview with director of nursing (DON) 12/21/16, at 2:03 p.m. DON stated that we try to have the care plans updated or revised completed within 72 hours. Until the revision is completed the information is passed on through report and/or memo stuck up at the nurse station. When asked about how they document for 1 hour checks, DON stated, "We have it documented with 30 minutes or less, any more than that we don't have them document." When asked how she would know that staff are checking hourly if not documented DON stated, "Technically I don't." The facility policy Resident Care Plan, dated revision 1/15/15, indicated Policy: b. it is the policy of the facility to provide clear communication to staff regarding the problems, needs and strengths of residents and hoe to properly care for them and follow the care plan. Procedure for care plan review and updating: a. The resident care plan is reviewed and revised by the interdisciplinary team as determined by the resident's needs and per MDS schedule.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 282		1/27/17

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 _____	12/21/2016

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 282	Continued From page 12 (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the care plan for 1 of 3 residents (R33) reviewed for activities of daily living who required assistance with shaving. Findings include: R33's care plan dated 11/1/16, directed R33 required assistance with activities of daily living and required assistance of one staff for personal hygiene. R33 was admitted to the facility 10/20/16, with diagnosis that included schizoaffective disorder and depression according to facility Resident Face Sheet. Facility resident Care Plan dated 11/1/16, identified R33 had a problem of left chest incision and drain sights due to left breast mastectomy. The facility identified R33 on the admission Minimum Data Set (MDS), an assessment dated 10/27/16, to have cognition intact, no behaviors, and required extensive assistance of one staff for personal hygiene which included shaving. Document review of R33's Care Area Assessment (CAA) dated 11/1/16, revealed R33 required extensive assistance for grooming/personal hygiene related to recent hospitalization, pain, weakness, limited range of motion, and visual impairment.	F 282	Kenyon Sunset Home strives to ensure that the services that are provided or arranged by the facility are always provided by qualified persons in accordance with each resident□s written plan of care. 1) R33□s care plan, closet care plan, resident care group sheets and bath list were reviewed and updated. R33 has been shaved, with focus on her chin hairs, with the assist of one staff. A sign off has also been included into her electronic point of care (POC) to ensure staff assistance of 1 with shaving on bath day and as needed. 2) All residents of Kenyon Sunset Home have the potential to be affected by this deficient practice. 3) The facility Bath Policies, as well as the facility Bath List have been reviewed and updated to include the expectation that all residents are to be shaved on their bath day, if they are accepting of it. The facility Bath Day Skin Check form that the CNAs complete with each bath has also been updated to include a sign off for shaving the resident. 4) The Director of Nursing or Registered Nurse designee will complete weekly audits for duration of 6 months, to monitor and to ensure residents are being shaved according to their wishes and policy. 5) Corrective action completion date:	

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 _____	12/21/2016

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 282	Continued From page 13 Document review of R33's nursing assistant care plan, revealed R33 was to be shaved with assistance of one staff. During observations on 12/19/16, at 5:19 p.m., R33 sat in a wheelchair in the resident's room. R33 was observed to have numerous, approximately 1/2 inch chin hairs covering all of the chin area. During interview at that time, R33 stated the facility beautician shaved chin hairs last week. R33 stated facility staff had not shaved chin hairs. R33 was observed to rubbed chin at that time and stated chin hairs were "kind of embarrassing." Observations on 12/20/16, at 12:30 p.m., revealed R33 continued to have many long chin hairs across all of the chin area. Document review of facility Bath Day Skin Checks, revealed the skin checks included nursing assistant documentation of resident baths, vital signs, skin checks, wash hair and beauty shop. The skin checks did not include identification of shaving residents. Bath Day Skin Checks reviewed for R33 included the following: 10/26/16, 11/2/16, 11/9/16, 11/16/16, 12/1/16, and 12/6/16. None identified shaving was provided. Skin check dated 11/9/16, was blank, with "refused" written across the top of the page. Review of skin check bath sheets revealed no indication that shaving was offered or completed on bath days. During interview on 12/20/16, at 1:08 p.m., licensed practical nurse (LPN)-A verified nursing assistant care plan directed assist of one staff for shaving. LPN-A stated did not know when R33 was last shaved. LPN-A stated residents were	F 282	January 27, 2017.	

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 _____	12/21/2016

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 282	Continued From page 14	F 282		

usually shaved on bath days and as needed. LPN-A verified R33 had long chin hairs and needed to be shaved.

During interview on 12/20/16, at 1:15 p.m., director of nursing verified R33 had long chin hairs. Director of nursing verified the facility care plan directed personal hygiene with assistance of one staff.

During interview on 12/20/16, at 2:20 p.m., nursing assistant (NA)-A stated residents were shaved on bath days and as needed.

During interview on 12/21/16, at 7:07 a.m., nursing assistant (NA)-B stated R33 was scheduled for a bath that day. NA-B stated R33 had not refused to be shaved as far as NA-B knew. NA-B stated residents were shaved on bath day and as needed.

During interview on 12/21/16, at 7:15 a.m., nursing assistant (NA)-C identified self as giving resident baths that day. NA-C stated gave baths, vital signs, skin checks and charted on Bath Day Skin Checks form and gave the form to the nurse.

During interview on 12/21/16, at 7:55 a.m., director of nursing verified staff do not document shaving residents. She verified the bath day skin check forms did not indicate shaving residents.

Document review of facility Activities of Daily Living policy dated 12/5/13, revealed Policy:
a. to assist each individual in achieving the highest level of self care as possible.
b. nursing interventions that assist or promote the individual's ability to maintain activities of daily

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 _____	12/21/2016

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 282	Continued From page 15 living functions. General Information: h. dressing or grooming: activities used to improve or maintain individual's performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.	F 282		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents reviewed for activities of daily living (R33), received assistance with shaving. Findings include: R33 was admitted to the facility 10/20/16, with diagnosis that included schizoaffective disorder and depression according to facility Resident Face Sheet. Facility resident Care Plan dated 11/1/16, identified R33 had a problem of left chest incision and drain sights due to left breast mastectomy. The facility identified R33 on the admission Minimum Data Set (MDS), an assessment dated 10/27/16, to have cognition intact, no behaviors, and required extensive assistance of one staff for personal hygiene which included shaving. Document review of R33's Care Area	F 311	Kenyon Sunset Home strives to ensure that residents are given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living. 6) R33□s care plan, closet care plan, resident care group sheets and bath list were reviewed and updated. R33 has been shaved, with focus on her chin hairs, with the assist of one staff. A sign off has also been included into her electronic point of care (POC) to ensure staff assistance of 1 with shaving on bath day and as needed. 7) All residents of Kenyon Sunset Home have the potential to be affected by this deficient practice. 8) The facility Bath Policies, as well as the facility Bath List have been reviewed and updated to include the expectation that all residents are to be shaved on their bath day, if they are accepting of it. The	1/27/17

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 _____	12/21/2016

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 311	Continued From page 16 Assessment (CAA) dated 11/1/16, revealed R33 required extensive assistance for grooming/personal hygiene related to recent hospitalization, pain, weakness, limited range of motion, and visual impairment. R33's care plan dated 11/1/16, directed R33 required assistance with activities of daily living and required assistance of one staff for personal hygiene. Document review of R33's nursing assistant care plan, revealed R33 was to be shaved with assistance of one staff. During observations on 12/19/16, at 5:19 p.m., R33 sat in a wheelchair in the resident's room. R33 was observed to have numerous, approximately 1/2 inch chin hairs covering all of the chin area. During interview at that time, R33 stated the facility beautician shaved chin hairs last week. R33 stated facility staff had not shaved chin hairs. R33 was observed to rubbed chin at that time and stated chin hairs were "kind of embarrassing." Observations on 12/20/16, at 12:30 p.m., revealed R33 continued to have many long chin hairs across all of the chin area. Document review of facility Bath Day Skin Checks, revealed the skin checks included nursing assistant documentation of resident baths, vital signs, skin checks, wash hair and beauty shop. The skin checks did not include identification of shaving residents. Bath Day Skin Checks reviewed for R33 included the following: 10/26/16, 11/2/16, 11/9/16, 11/16/16, 12/1/16, and 12/6/16. None identified shaving was provided.	F 311	facility Bath Day Skin Check form that the CNAs complete with each bath has also been updated to include a sign off for shaving the resident. 9) The Director of Nursing or Registered Nurse designee will complete weekly audits for duration of 6 months, to monitor and to ensure residents are being shaved according to their wishes and policy. 10) Corrective action completion date: January 27, 2017.	

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 _____	12/21/2016

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 311	Continued From page 17 Skin check dated 11/9/16, was blank, with "refused" written across the top of the page. Review of skin check bath sheets revealed no indication that shaving was offered or completed on bath days. During interview on 12/20/16, at 1:08 p.m., licensed practical nurse (LPN)-A verified nursing assistant care plan directed assist of one staff for shaving. LPN-A stated did not know when R33 was last shaved. LPN-A stated residents were usually shaved on bath days and as needed. LPN-A verified R33 had long chin hairs and needed to be shaved. During interview on 12/20/16, at 1:15 p.m., director of nursing verified R33 had long chin hairs. Director of nursing verified the facility care plan directed personal hygiene with assistance of one staff. Document review of facility Activities of Daily Living policy dated 12/5/13, revealed Policy: a. to assist each individual in achieving the highest level of self care as possible. b. nursing interventions that assist or promote the individual's ability to maintain activities of daily living functions. General Information: h. dressing or grooming: activities used to improve or maintain individual's performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.	F 311		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		1/27/17

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 _____	12/21/2016

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 323	Continued From page 18 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the use of side rails for 1 of 1 resident (R12) who utilized bed rails. Findings include: R12 was admitted to the facility on 11/4/16 according to the Resident Face Sheet which also identified an admission diagnosis of dementia, pubis fracture and epilepsy. A Brief Interview for Mental Status (BIMS) dated 11/9/16, indicated R12 was cognitively intact.	F 323	Kenyon senior living strives to provide a safe environment for all residents. 1) R12 discharged to her assisted living apartment on 12/21/17. 2) All residents who reside at Kenyon Sunset Home have the potential to be affected by the same deficient practice. 3) A side rail policy has been written for Kenyon Sunset Home, RN staff educated on the policy. Side rail assessments have been completed on all residents at KSH who use side rails. Upon admission side rails are used after alternatives have been attempted and side rail assessments have	

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 _____	12/21/2016

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 323	Continued From page 19 During observation on 12/19/16, at 2:56 p.m., R12 was at an activity when his room was checked. During the room observation R12's bed was against one wall and on the open side there had been a 1/2 side rail in the up position. There was a gap observed between the side rail and the mattress that measured 7.5 inches at the top of the rail and 3.5 inches between the bottom of the rail and the mattress. The director of nursing (DON) was asked to come to R12's room on 12/19/16, at 5:00 p.m. The DON confirmed the gap between the mattress and side rail. The DON was asked to pull the bed away from the wall, there is another 1/2 side rail in the down position. The DON stated the nursing facility did not do any type of side rail safety assessment for R12. On 12/19/16, at 6:35 p.m. R12 was interviewed. During the interview R12 denied and difficulty transferring in and out of bed or having issues with the short mattress and siderail. R12 stated she didn't use the siderail except to hang the call light on it. R12's care plan with a date of 11/16/16, had identified the need for assistance with activities of daily living due to fracture of pelvis from a recent fall at Assisted Living and also has epilepsy. The care plan did identify there were 2 grab rails to assist resident in bed mobility. An entry in the electronic medical record (EMR) dated 11/10/2016, at 6:01 a.m. indicated R12 had "half head rails" to assist with turning and repositioning. Another entry in the EMR dated 11/11/16, at 3:00 a.m. indicated R12 did use the	F 323	been completed. Prior to use of side rails, the risks and benefits are reviewed with resident and/or representative and informed consent is obtained. Proper fit, function and condition of side rails is assessed prior to use. The facility follows the FDA entrapment zone guidelines for appropriate gap measurements in all bed zones. Residents are provided with appropriate sized beds for their size and weight. 4) The DON or designee will audit completion of side rail assessments weekly for completion and appropriateness of use, documentation of trial of alternative, and proper consent obtained. Twice weekly audits will be done by the DON or designee to monitor appropriate use of side rails, visual condition proper functioning, and appropriate gap in all zones of entrapment. The audits will be completed for a 6 month duration and prn thereafter. 5) Completion date: January 27,2017	

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 _____	12/21/2016

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 323	Continued From page 20 call light as needed to obtain staff assistance with cares. The entry in the EMR indicated R12 was at the nursing facility for short term rehabilitation stay. R12 was recuperating following a fall with right pelvic fracture. R12 required one staff to assist with bed mobility and there were "1/2 side rails up when in bed to assist with bed mobility and repositioning." On 12/21/2016, at 1:06 p.m. the DON and licensed social work (LSW) confirmed the facility was not assessing for the use of grab bars or side rails when used by residents. When asked how the staff determine who receives grab bars or side rails, the DON stated that it was resident choice. A side rail policy was requested but not received.	F 323		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329		1/27/17

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 _____	12/21/2016

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 21 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify specific resident centered signs/symptoms to determine if an antipsychotic medication, antidepressant medication and hypnotic medication (including a comprehensive sleep assessment) was affective for 1 of 5 residents (R26) who had been reviewed for unnecessary medication use. Findings include: R26's annual Minimum Data Set (MDS) dated 10/4/16, identified moderate cognitive impairment, mood symptoms of little interest in doing things, feeling down, trouble falling asleep, feeling bad about self, trouble concentrating, move or speak slowly, thought better off dead. Behaviors of physical, verbal, other behaviors not directed towards others, rejection of care, change in behavior worse and diagnosis of dementia. R26's physician orders identified, 9/16/16 Divalproex (Depakote) (a medication used for behaviors) 125 mg (milligrams) three times a day for dementia with behavioral disturbance, 10/4/16 Zoloft (antidepressant) 50 mg every a.m. for depression, 10/21/16 increase Trazodone (antidepressant) to 50 mg at bedtime for insomnia and 12/8/16 Seroquel (antipsychotic) 12.5 mg twice daily with increase to 25 mg twice daily on 12/19/16 for dementia with behavioral disturbances. R26's medication administration record dated 12/2016, identified R26 was receiving the medications as ordered.	F 329	Kenyon Sunset Home strives to ensure each resident□s medication regimen is free from unnecessary medication. 1) A new sleep monitoring and sleep assessment is being completed for R26. Specific targeted behaviors are being monitored for each psychotropic medication. Resident receives divalproex TID, specific targeted behaviors are upset/agitated, showing fist/ threatening staff. He receives Seroquel BID, specific targeted behaviors are paranoia, statements of being watched/followed, wandering into others rooms/rummaging. Specific targeted behaviors for Zoloft are statements of feeling bad about himself, feeling bad about asking for help. Specific targeted behavior for his Trazadone is number of times awake at night. 2) All residents who receive psychotropic medications have the potential to be affected by the same deficient practice. 3) Targeted behaviors are reviewed for all residents receiving psychotropic medications weekly by the IDT. The IDT reviews appropriate targeted behaviors for each medication. Psychotropic medications are reviewed quarterly per MDS schedule for appropriateness. Pharmacy consultant reviews medications monthly for appropriateness. 4) The DON or designee will audit behavior monitoring sheets for completion and appropriate targeted behaviors twice	

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 _____	12/21/2016

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 22 R26's resident progress note dated 10/4/16, documented by social services (SS)-A, identified PHQ-9 (Patient Health Questionnaire, a test used to screen for depression): met with resident to complete PHQ-9. Resident's family member (FM)-A acted as interpreter for LSW (licensed social worker). Resident was concerned about his frequency of needing to use the restroom and his urgency. He expressed that he felt bad for always having to get help and wait for help. Expressed to him that staff are there to help him whenever he needs it. When asked about feeling bad about self and wishing he was dead he expressed that he feels this way very much. He stated that sometimes he will let himself fall in hopes that he is injured. This was discussed with director of nursing. Medical doctor will be faxed regarding this and if feels an antidepressant could be beneficial. LACK OF MONITORING SPECIFIC SYMPTOMS FOR THE USE OF A MOOD ALTERNATING MEDICATION, AN ANTIDEPRESSANT MEDICATION AND SPECIFIC TARGET BEHAVIORS FOR THE USE OF AN ANTIPSYCHOTIC MEDICATION. R26's care plan dated 10/19/16, included psychotropic drug use problem: resident is at risk for adverse consequences related to receiving Depakote, Zoloft and trazodone medication for treatment of Dementia with behavior issues and insomnia. Resident started on Zoloft and Depakote increased due to increased signs and symptoms of depression and behaviors. Assess/record effectiveness of drug treatment. Monitor and report signs of sedation, anticholinergic and/or extrapyramidal symptoms. Assess/record effectiveness of drug treatment. Monitor and report signs of sedation,	F 329	weekly for duration of 6 months and as needed thereafter. 5) Completion date: January 27,2017	

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 _____	12/21/2016

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 23	F 329		

hypotension, or anticholinergic symptoms. Attempt gradual dose reduction (GDR) without affecting results. Document how well resident sleeps. Give trazodone a half hour before bedtime. Monitor for increase in anxiety or depression. Pharmacy consult per routine. Quantitatively and objectively document the resident's mood. TD (Tardive Dyskinesia) assessments quarterly. Valporic labs per physician orders and report abnormal findings.
R26's behavior sheets dated 12/16, identified behavior:1. upset/agitated with interventions of 1:1 visit, snack, redirect, call family for translation. 2. sexual behaviors - flirting with staff with interventions of redirect, re-approach and offer choices.
However, R26's record failed to identify specific signs and symptoms of depression to monitor to determine if the medication is affective or not. Also failed to identify specific signs and symptoms to determine if both the use of Depakote and Seroquel were associated with the prescribed Zoloft for the diagnosis of depression, what specific target behaviors were associated with the prescribed Seroquel for diagnosis of dementia with behavioral disturbances, what specific symptoms were associated with the prescribed Depakote for diagnosis of dementia with behavioral disturbances and specific interventions related to the use of the medications.

LACK OF SLEEP MONITORING/ASSESSMENT FOR THE INCREASED USE OF AN ANTIDEPRESSANT MEDICATION FOR INSOMNIA
R26's care plan dated revised 10/19/2016, indicated problem: disturbed sleep pattern. Resident is up a portion of some nights and is

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 _____	12/21/2016

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 24 confused thinking its daytime. Administer medications: Trazodone. Monitor and record effectiveness. Report adverse side effects. Assess resident for presence/absence of sleep apnea. Avoid over-stimulation and exercise close to bedtime. Do not turn on light during room check. Encourage resident to go to bed at the same time every day and wake up at the same time every day. Give bedtime snack at night and document if he refuses snack. Organize care to limit sleep interruptions. Provide comfortable environment to promote sleep, Provide pain relief measures before bedtime. Reduce environmental disruptions. When resident awakens during the night, provide comfort measures (back rub, repositioning, incontinence care, snack) and encourage continued rest/sleep. Ask resident if he has pain. R26's record identified Sleep Pattern sheet dated 6/8/16 through 6/14/16, which monitored hours of awake time and sleep time. A consultant pharmacist note dated 9/27/16, indicated per nursing reports R26 is frequently up at night and a gradual dose reduction may not be indicated at this time. If a gradual dose reduction is not indicated, please provide rationale as to why. The physician response dated 10/21/16, was plan to increase Trazodone to 50 mg at bedtime with insomnia issue. On 12/21/16, at 11:26 a.m., the director of nursing (DON) confirmed the physician had not documented justification for the increase in the Trazodone, for the start of the Zoloft or Seroquel. The DON stated she would expect sleep monitoring to be completed with a change in medication. The DON stated the facility does not complete a sleep assessment, we just do sleep monitoring.	F 329		

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 _____	12/21/2016

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 25 The facility Psychotropic Mediations - Use of Policy and Procedure dated 2/7/13, indicated Policy: a. All residents who are on psychotropic medications will be assessed for use on admission, readmission, with changes in condition, and quarterly by the interdisciplinary team. b. A resident will not receive psychotropic medications unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's target behavior disturbance. A resident will not receive psychotropic medications unless such medication is needed to treat specific condition and each psychotropic medication will be given to treat clearly defined target behaviors. c. Consistent monitoring of all target behaviors will be done to assist in the assessment of the risks and benefits of psychotropic medication. f. A psychotropic medication will be defined as any medication which is prescribed for the purpose of modifying mood and/or behavior. Target Behavior: a. For each psychotropic medication administered, there will be at least one measurable target behavior identified. Documentation: a. Prior to the administration of an antipsychotic medication the following must be documented: ii. Target behaviors will be identified will supporting documentation in the clinical record. iv. Plan of car including treatment goals, evaluation of any precipitating factors in the resident's environment, and any non-drug approaches to providing care. The facility Sleep Assessment and Sleep Monitoring Policy dated 11/19/15, indicated Procedure: a. Nurse manager will gather sleep assessment data on admission and document it in the admission assessment. Sleep assessment will be repeated quarterly and as needed. b. All residents on admission and quarterly will have a	F 329		

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 _____	12/21/2016

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 26 three day sleep log completed by the nursing staff on all three shifts to monitor sleep patterns. c. Nurse manager will summarize sleep log and determine if the resident is having insomnia problems. f. Continued monitoring of residents with sleep disorders receiving sleep medications will be completed via sleep logs with quarterly assessments and with any sleep medication dose adjustments (increases, decreases, discontinuation of sleep medication). Residents receiving psychotropic medications also have daily behavior observation sheets completed to monitor target behaviors, interventions, and outcomes.	F 329		
F 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 441		1/27/17

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 _____	12/21/2016

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 441	Continued From page 27 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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 _____	12/21/2016

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 441	Continued From page 28 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation of three signs and symptoms related to urinary tract infections (UTI) prior to use of an antibiotic (Antibiotic stewardship) for 2 out of 3 residents (R44 and R21); failed to ensure analysis and surveillance of infections. Findings include: LACK OF ANTIBIOTIC STEWARDSHIP WHEN TREATING UTI WITHOUT IDENTIFYING A MINIMUM OF THREE SIGNS AND SYMPTOMS TO DETERMINE IF UTI WAS TREATABLE WITH ANTIBIOTICS: R44's progress note dated 12/10/16 included resident stated she would like Cipro (antibiotic) as she feels she has a UTI. Urine sample obtained and taken to the emergency room for processing per family request. Two days later on 12/11/16 telephone order from physician received for Cipro 500 mg (milligrams) twice daily for seven days. R44's medication administration record (MAR) identified R44 had received the medication as ordered. However, R44's medical record did not have three signs/symptoms of urinary tract infection to warrant the use of an antibiotic. On asking the facility for evidence of UTI symptoms/signs none was provided. On 12/21/16, at 2:29 p.m., the director of nursing (DON) confirmed R44's record lacked documentation of three signs and symptoms for	F 441	Kenyon Sunset Home strives to maintain an established Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. 1) a. R 44 discharged to home on 1/8/2017. Her antibiotic course was completed on 12/22/16. R21 remains in the facility; his course of antibiotics was completed on 9/20/2016. The infection control nurse was re-educated on including 3 signs and symptoms to be included with each UTI. b. Infection control nurse was re-educated on the importance of document resolution and surveillance of all infections, including infection control precautions used to prevent the spread of infections. 2) All residents residing at Kenyon Sunset home have the risk to be affected by the same deficient practice. 3) a. All infections are reviewed weekly by the IDT. A new form was developed to assist nursing in documenting 3 signs and symptoms of each suspected UTI when requesting a urine sample from the MD/CNP. b. Infection control log forms were updated to include information on infection control precautions used; area to mark that resolution of infection was documented. 4) a. The DON or designee will audit	

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 _____	12/21/2016

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 441	Continued From page 29 UTI. R21's had a fax dated 8/31/16 and sent to physician related to a fall, physician response order to check urinalysis and urine culture. Another fax dated 9/8/16 had been sent to physician related to fall, physician order for Bactrim DS (double strength) (antibiotic) one tablet twice daily for 10 days. R21's MAR dated 9/16 identified R21 had received the medication as ordered. However, there were no identified signs/symptoms of a urinary tract infection to warrant the use of an antibiotic. On 12/21/16, at 2:29 p.m., the DON stated the physician ordered the urinalysis and urine culture related to falls and confirmed R21's record lacked documentation of three signs and symptoms for an active UTI. LACK OF SURVEILLANCE AND ANALYSIS OF NURSING HOME WIDE INFECTIONS: The facility monthly Infection Control Logs were obtained from 11/2015 through 11/2016. The logs identified for tracking the resident name and room, date admit, date onset, site, infection diagnosis, culture, x-ray date, organism, antibiotic, isolated, nosocomial, re-culture date and date resolved. The logs identified the following infections: 11/16 - 2 sinusitis, 1 heel wound, 1 face wound, 1 UTI 10/16 - 1 c-diff (stool infection), 1 tooth 9/16 - 2 tooth, 3 UTI, 2 yeast, 1 wound, 1 bronchitis 8/16 - 1 wound, 2 pneumonia, 1 tooth 7/16 - 2 wound, 3 UTI, 1 yeast, 1 URI (upper	F 441	infection control logs weekly for completion, documentation of 3 signs and symptoms for all UTIs. b. Audits will be done to ensure completion of documentation of resolution of infection weekly. All audits will be completed for duration of 6 months and as needed thereafter. 5) Completion date: January 27,2017	

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 _____	12/21/2016

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 441	Continued From page 30 respiratory infection) 6/16 - 1 UTI, 2 wound 5/16 - 3 UTI, 1 URI 4/16 - 2 UTI, 2 URI, 1 wound, 1 cellulitis (skin infection), 1 c-diff 3/16 - 1 UTI, 3/16 - 6 URI/pneumonia, 1 wound, 1 UTI, 1 joint/knee (intraoperative) 2/16 - 4 URI, 2 cellulitis, 3 UTI, 1 eye 1/16 - 1 UTI, 4 URI/pneumonia, 1 GI (gastrointestinal), 1 sinusitis, 1 prostatitis, 1 eye 12/15 - 2 UTI, 1 yeast, 1 wound, 1 skin 11/15 - 2 URI/pneumonia However, the logs failed to include signs and symptoms of the infection and the facility failed to document ongoing surveillance and analysis of the information to and infection control precautions used to prevent the spread of the infections. On 12/21/16 at 2:38 p.m., the DON confirmed the logs failed to include signs and symptoms. The DON stated she does not document analysis and surveillance of infections. Staff are just reminded to wash hands. The policy and procedure for the facility infection control program was requested on 12/19/16. The director of nursing provided the following policies: Infection Control dated revised on 11/19/15, read, I. Infection Control a. Kenyon Senior Living (KSL) will provide a sanitary and comfortable environment and endeavor to prevent the development and transmission of infection. b. Employees will practice the use of Universal Precautions as recommended by the Center of Disease Control (CDC) when handling blood and	F 441		

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 _____	12/21/2016

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 441	Continued From page 31	F 441		

other body fluids. c. The KSL procedure will follow CDC, Sate, Federal and OSHA standards and guidelines for infection prevention, control, and surveillance. d. There is ongoing Quality Assessment and Assurance (QAA) Program designed to objectively and systematically monitor and evaluate the quality and appropriateness of resident care, pursue opportunities to improve resident care and resolve identified problems. The QAA program oversees the effectiveness of monitoring and evaluation including infection control. e. There is a designated infection control person (ICP) who is responsible for organizing an infection control program within the facility who is knowledgeable about or has experience or a special interest in infection control.

Infection Control Surveillance Policy revision date 11/19/15, read, I. Policy a. It is the policy of Kenyon Sunset Home (KSH) to perform routine surveillance of residents, staff and the environment. The primary purpose of the infection control surveillance is the collection of information to ensure that precautions are in place or implemented or necessary measures are taken to prevent the spread of infection. II. Procedure a. Our infection control registered nurse (RN) is responsible for monitoring the infection control log and sheets. b. Our safety committee is responsible for performing the monthly infection control audits as well as the infection control and hand washing audits.

Facility policy Outbreak revision date 12/17/14, read I. Policy a. In the event of a facility outbreak, it is the policy of KSH to notify our Medical Director immediately for further directions. II. Procedure a. Depending on outbreak type

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 _____	12/21/2016

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 441	Continued From page 32 (influenza or respiratory) the Medical Director may prescribe a medication to all current residents and those being admitted that current week. i. Staff is recommended to also seek medical care if symptoms present themselves in order to treat immediately. b. Complete the infection control sheet if an antibiotic was started. c. Add the UTI information on the follow-up charting record. d. Follow up on the infection control sheet when an antibiotic is completed. i. The completed infection control sheet is to be turned into the infection control RN. e. Infection control RN will document residents and staff that have signs or symptoms associated with the facility outbreak. f. Contact the family for any changes and report resident's current status.	F 441		

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 _____	**12/21/2016**

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	INITIAL COMMENTS FIRE SAFETY Aspen with Deficiencies 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 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. 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 compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/16/2017

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.

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 _____	**12/21/2016**

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 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@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 with a partial basement. The original building was constructed in 1966 and was determined to be of Type II(222) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 30 beds and had a census of 26 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 200 SS=D	NFPA 101 Means of Egress Requirements - Other	K 200		1/12/17

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 _____	**12/21/2016**

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 200	Continued From page 2 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This STANDARD is not met as evidenced by: Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on observation and interview revealed the following include: Computer stands located in corridors stick out from walls more than 6 inches. LSC 19.2.3.4(2) This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 200	1) Kenyon Sunset Home will ensure that facility computer stands located in the facility corridors stick do not stick out from the wall more than 6 inches. 2) Kenyon Sunset Home has completed this on January 12, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this.	

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 _____	**12/21/2016**

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 200	Continued From page 3 discovery.	K 200		
K 211 SS=F	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on observation and interview revealed the following include: Wheelchairs were found being stored in all corridors. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 211	1) Kenyon Sunset Home will ensure that all aisles, passageways, corridors, exit discharges, exit locations and accesses and the means of egress are continuously free of all obstructions. Kenyon Sunset Home 2) Kenyon Sunset Home completed this on January 11, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this. Facility Safety Committee will also be completing scheduled audits of this.	1/11/17
K 222	NFPA 101 Egress Doors	K 222		1/11/17

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 _____	**12/21/2016**

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 222 SS=F	Continued From page 4 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		

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 _____	**12/21/2016**

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 222	Continued From page 5 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on observation and interview the following include: Dead bolt locks were found on exit doors and were not disabled. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment.	K 222	1) Kenyon Sunset Home will ensure that doors in a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Kenyon Sunset Home has ensured that all dead bolt locks on exit doors are disabled 2) Kenyon Sunset Home competed this on January 11, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this.	

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 _____	**12/21/2016**

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 222	Continued From page 6 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 222		
K 291 SS=F	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on documentation review and interview that the following include: There was no record of back-up emergency light units being check for 30 second monthly and 90 minute annual testing. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	1) Kenyon Sunset Home will ensure that back-up emergency lighting units are being tested for a minimum of 30 seconds monthly as well as a minimum of 90 minutes annual, and a log of such will be kept. 2) Kenyon Sunset home completed this on January 11, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this.	1/11/17
K 293 SS=F	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination	K 293		1/11/17

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 _____	**12/21/2016**

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 293	Continued From page 7 also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on observation and interview revealed the following include: Exit sign on west wing was not operation. Check all exit signage through-out facility. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartments. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 293	1) Kenyon Sunset Home will ensure that all exit and directional signs in the facility have continuous illumination and are functioning properly. 2) Kenyon Sunset Home completed this on January 11, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this.	
K 345 SS=F	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		1/11/17

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 _____	**12/21/2016**

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 345	Continued From page 8 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on documentation review and interview that the following include: Records show there was no data test of fire alarm system for 3rd shaft night fire drills. This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	1) Kenyon Sunset Home will ensure that the facility fire alarm system is tested and maintained in accordance with the requirements. Kenyon Sunset Home will ensure that there is a record of data tests of the fire alarm system during the overnight shift fire drills. 2) Kenyon Sunset Home completed this on January 11, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this.	
K 354 SS=F	NFPA 101 Sprinkler System - Out of Service	K 354		1/16/17

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 _____	**12/21/2016**

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 354	Continued From page 9 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on documentation review and interview that the following include: Revise your out of service plan with current contact information and times for being out of service per Life Code Code 101 (2012)	K 354	1) Kenyon Sunset Home will ensure that the facility Fire Protection Systems Out of Service Policy is updated to provide instruction on what is to be done if the facility sprinkler system is out of service for more than 10 hours in a 24 hour period. Kenyon Sunset Home has also ensured that contact information within this policy has been updated and is current. 2) Kenyon Sunset Home completed this on January 16, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this.	

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 _____	**12/21/2016**

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 354	Continued From page 10 This deficient practice could affect the safety of all the residents, staff and visitors within the facility. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 354		
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system	K 372	1) Kenyon Sunset Home will ensure that smoke barriers shall be constructed to a ¿ hour fire resistance rating from floor to deck above smoke barrier doors. 2) Kenyon Sunset Home will have this completed by January 27, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this.	1/27/17

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 _____	**12/21/2016**

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 372	Continued From page 11 in REMARKS. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on observation and interview revealed the following include: Smoke barrier for east wing does not continue from floor to deck above smoke barrier doors. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712	1) Kenyon Sunset Home will hold fire drills at unexpected times under varying conditions, at least quarterly on each shift.	1/11/17

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 _____	**12/21/2016**

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 712	Continued From page 12 conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Findings Include: On facility tour between 09:00 AM and 01:00 PM on 12/21/16, based on documentation review and interview that the following include: The review of the fire drill documentation for the past 12 months (December 2015 to November 2016) revealed that the drills for the following shifts were completed, but did not sufficiently vary the times that the drills were conducted: Day: 920am, 1115am, 920am and 1130am. Evening: 215pm, 0405pm, 205pm and 350pm Nights: 100am, 110am, 105am and 345am This deficient practice could affect the safety of all the residents, staff and visitors within the facilty. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	Kenyon Sunset Home will complete the fire drills at least quarterly on each shift and at varying times, with at least an hour and half time difference between the drills. 2) Kenyon Sunset Home competed this on January 11, 2017. 3) Director of Maintenance, Tom Biers, is responsible for the correction, completion and monitoring of this.	