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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YV7B

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 **02/15/2013** (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 **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 02/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 04/07/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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
Posted 4/12/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/05/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

On February 25, 2013, a Post Certification Revisit (PCR) by review of the plan of correction was completed by the Department of Health and on February 21, 2013, the Minnesota Department of Public Safety completed a PCR. Based on the PCR, it has been determined that the facility has achieved substantial compliance pursuant to the January 10, 2013 standard survey, effective February 21, 2013. Refer to the CMS-2567b for both health and life safety code.

Effective February 21, 2013, the facility is certified for 43 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5379

April 7, 2013

Mr. David Vandergon, Administrator
Kenyon Sunset Home
127 Gunderson Boulevard
Kenyon, Minnesota 55946

Dear Mr. Vandergon:

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 February 21, 2013 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 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.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 26, 2013

Mr. David Vandergon, Administrator
Kenyon Sunset Home
127 Gunderson Boulevard
Kenyon, Minnesota 55946

RE: Project Number S5379022

Dear Mr. Vandergon:

On January 29, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 10, 2013. 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 25, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 21, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 10, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 19, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 10, 2013, effective 02/21/2013 and therefore remedies outlined in our letter to you dated January 29, 2013, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5379r13.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing	2/25/2013

Name of Facility	Street Address, City, State, Zip Code
KENYON SUNSET HOME	127 GUNDERSON BOULEVARD KENYON, MN 55946

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **02/19/2013**	ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **02/19/2013**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **02/19/2013**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **02/19/2013**	ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	Correction Completed **02/19/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **02/19/2013**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **02/19/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/19/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **02/19/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **02/19/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **02/19/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **02/19/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **02/19/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GPN	02/26/2013	10160	02/25/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/10/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing **01 - MAIN BUILDING 01**	2/21/2013

Name of Facility	Street Address, City, State, Zip Code
KENYON SUNSET HOME	127 GUNDERSON BOULEVARD KENYON, MN 55946

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0050	**02/21/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GPN	02/26/2013	25822	02/21/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 1/7/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YV7B

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 **01/10/2013** (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 IMR**	**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 **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	43			
(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):

At the time of the January 10, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NEII 02/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/01/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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
Posted 3/5/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 5457

January 29, 2013

Mr. David Vandergon, Administrator
Kenyon Sunset Home
127 Gunderson Boulevard
Kenyon, Minnesota 55946

RE: Project Number S5379022

Dear Mr. Vandergon:

On January 10, 2013, 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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - 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
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904

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 February 19, 2013, 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 February 19, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 April 10, 2013 (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 July 10, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

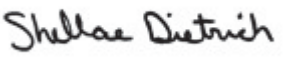
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5379s13.rtf

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 _____	01/10/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	See Attachment # 1 2-20-13 JSPN	2/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Ann Stark RN BSN — TITLE: Director of Nursing — (X6) DATE: 2/8/13

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

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	245379	A. BUILDING _____ B. WING _____	01/10/2013

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and	F 156		

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide appropriate Medicare non-coverage notices for 2 of 3 residents (R13 and R53) reviewed in the sample, who were discharged from Medicare.	F 156		

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F 156	Continued From page 3 Findings include: R13, and R53 did not receive a Notice of Medicare Provider Non-Coverage, which informed residents of the right to an expedited review by the Quality Improvement Organization (QIO) when Medicare services were terminated. R13 lacked Notice of Medicare Provider Non-Coverage which included the right to expedited review by the QIO. R13 was admitted to the facility on 8/23/12. R13 was notified services were no longer covered by Medicare beginning 9/21/12. R13 did not receive Notice of Medicare Provider Non-Coverage which included the right to expedited review by the QIO. R53 lacked Notice of Medicare Provider Non-Coverage which included the right to expedited review by the QIO. R53 was admitted to the facility on 8/7/12. R53 was notified services were no longer covered by Medicare beginning 9/7/12. R53 did not receive Notice of Medicare Provider Non-Coverage which included the right to expedited review by the QIO. On 1/9/13, at 10:43 a.m. the director of nursing (DON) verified R13, R53, had received services covered under Medicare part A, the facility terminated Medicare services, and they had not exhausted their Medicare days. On 1/9/13, at 10:55 a.m. the registered nurse (RN)-A stated when a resident no longer qualified for services to be covered by Medicare, the procedure was to provide the resident with the facility notice Skilled Nursing Facility (SNF) Determination on Continued Stay. RN-A verified the facility failed to provide residents with the	F 156		

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F 156	Continued From page 4 "Notice of Medicare Provider Non-Coverage" which informed residents of the right to an expedited review by the QIO when Medicare services were terminated. She verified the expedited review information was not included on the facility SNF Determination on Continued Stay notice used by the facility. RN-A verified facility practice was to provide the Notice of Medicare Provider Non-Coverage when residents remained in the facility.	F 156		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to resolve a grievance for 1 of 2 residents (R11) in the sample whose grievances were reviewed. Findings include: R11 reported lack of working television stations without repair. A social service quarterly review dated 12/6/12 revealed R11 liked to spend much of their time in their recliner watching television and reading books. A quarterly interdisciplinary note dated 12/12/12, revealed R11 was alert and oriented with no cognitive impairment. On 1/7/13, at 11:15 a.m. R11 stated their preferred activities were to watch television and	F 166	See Attachment #2	2/19/13

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F 166	Continued From page 5 do crosswords in their room. R11 stated the television in their room was a facility television and that one television station had no sound and two other stations had no sound or picture. R11 stated one of the favorite stations had not worked "for a long time." R11 stated they had reported the lack of stations to the maintenance staff and to several other staff and it had not been fixed yet. On 1/9/13, at 2:15 p.m. the maintenance supervisor stated he was aware of problems with the television stations and lack of sound for R11. He stated in the past he had reset the receiver channel located in the mechanical room. He verified it had not fixed the problems and stated he would have to call the television repairman today.	F 166		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported	F 225	See attachment #3	2/19/13

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F 225	Continued From page 6 immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility had failed to immediately report to the administrator and state agency and had not completed a thorough investigation in regards to an allegation of resident abuse for 1 of 4 residents (R35) reviewed in the sample for abuse and vulnerable adult issues. Findings include: R35 experienced family to resident verbal abuse and physical safety concerns without immediately reporting the incident to the administrator and SA - the Office of Health Facility Complaints (OHFC) and did not thoroughly investigate the incident. Interdisciplinary Team Notes dated 11/19/12, at	F 225		

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F 225	Continued From page 7 1:29 p.m. indicated the licensed practical nurse (LPN)-A documented the family interaction with R35 during a visit. The note indicated R35 had reported she did not want to eat, drink, or sit in the chair and that R35's daughter was "quite firm and loud to resident demanding [R35] to eat, drink, and get out of bed." Also, R35 had complained of being short of breath and the daughter replied "Your [sic] breathing just fine." LPN-A documented the more R35 complained, the more forceful the daughter became. Social service (SS) notes from 11/28/12, to 12/5/12, were reviewed and did not indicate that neither the administrator, state agency nor an investigation having been done in regards to the allegation of abuse. On 1/10/13, at 2:00 p.m. the DON stated she was aware of the family/resident interactions that occurred on 11/19/12 but had not reported it as an allegation of abuse to the administrator or state agency. On 1/10/13, at 3:05 p.m. the administrator stated about three times a year the facility had resident/family problems, but he could not remember if he had been notified about R35 ' s allegation of abuse from family.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	See Attachment #4	2/19/13

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F 226	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement its Vulnerable Adult/Abuse Prevention Policy by immediately reporting allegations of resident abuse by family to the administrator and the state designated agency. Also the facility failed to thoroughly investigate the allegation of abuse for 1 of 4 residents (R35) in the sample reviewed for vulnerable adult abuse/neglect. Findings include: R35 experienced family to resident verbal abuse and physical safety concerns without the incident immediately being reported to the administrator and the state agency (Office of Health Facility Complaints) or thoroughly investigating the incident in accordance with the facility Vulnerable Adult/Abuse Prevention Policy. The Vulnerable Adult/Abuse Prevention Policy dated 1/16/12, indicated "It is the right of each individual resident to be free from verbal, sexual, physical and mental abuse, financial exploitation, corporal punishment and involuntary seclusion as defined in the Adult Protection Act." The policy directed, "The Law stipulates that all employees are considered mandated reports [sp] of any suspected incidents of maltreatment/neglect. They are to report immediate if: ....If it is believed that the incident was not an accident and was done with intentions of harming the resident, the Social Worker/Director of Nursing must be contacted immediately as it has to be reported within 2 hours of occurring." The policy indicated, "A staff member, volunteer or family member	F 226		

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F 226	Continued From page 9 must contact by phone any one of the following immediately: Administrator, DON, or Social Worker, or a supervisor; Goodhue County Social Services (CEP [common entry point]) at [phone number]; Goodhue County Sheriff's Office at [phone number] Social Worker/Director or nursing will then make an initial report of an incident within 24 hours of incident occurring. If it is believed that the incident was not an accident and in fact had intentions of harming the resident Social Worker/Director of Nursing must complete an initial report of the incident within 2 hours of incident occurring." The policy directed in bold type, "In all reports, the administrator must be notified immediately of a suspected VA [vulnerable adult] complaint." Also, "Residents, the alleged perpetrator, and other staff will be protected from harm during an investigation." Interdisciplinary Team Notes dated 11/19/12, at 1:29 p.m. indicated the licensed practical nurse (LPN)-A documented the family interaction with R35 during a visit. The note indicated R35 had reported she did not want to eat, drink, or sit in the chair and that R35's daughter was "quite firm and loud to resident demanding [R35] to eat, drink, and get out of bed." Also, R35 had complained of being short of breath and the daughter replied "Your [sic] breathing just fine." LPN-A documented the more R35 complained, the more forceful the daughter became. Social service (SS) notes from 11/28/12, to 12/5/12, were reviewed and did not indicate that neither the administrator, state agency nor an investigation having been done in regards to the allegation of abuse.	F 226		

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F 226	Continued From page 10 On 1/10/13, at 2:00 p.m. the DON stated she was aware of the family/resident interactions that occurred on 11/19/12 but had not reported it as an allegation of abuse to the administrator or state agency. On 1/10/13, at 3:05 p.m. the administrator stated about three times a year the facility had resident/family problems, but he could not remember if he had been notified about R35's allegation of abuse from family.	F 226		
F 257 SS=E	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain comfortable room temperatures for 5 of 29 residents (R34, R25, R12, R23, and R32) in the sample with complaints of cold resident rooms. Findings include: R34, R25, R12, R23, R32 expressed resident rooms were cold. During observations on 1/8/13, at 3:00 p.m., thermostat located outside room 214 and near room 212, was set at 78 degrees Fahrenheit but the temperature registered at 70 degrees. During observations at that time, rooms 212, 214, and the hallway outside the rooms felt cool. During	F 257	See Attachment #5	2/19/13

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F 257	Continued From page 11 observations at that time, R34, R25, and R23 were dressed with long sleeves and sweaters and were covered in blankets as they watched television. During interview on 1/08/13, at 3:29 p.m., R34 stated the room was cold but the facility was fixing it. During observations on 1/8/13, at 3:00 p.m., R34 was dressed in long sleeves, sweater, and covered with a blanket. During observations on 1/7/13, at 2:51 p.m., R25's room and the hallway felt cool. During interview on 1/08/13, at 4:20 p.m., R25 stated the room was cold. R25 stated the facility had a part missing (in regards to the heating unit) for a week or more and it was ordered. R25 stated used a couple blankets and afghan to keep warm. During interview on 1/08/13, at 3:49 p.m., R23 stated it was so cold in the room, but the facility said someone had been " messing " with the thermostat. R23 stated there used to be two thermostats, one inside the resident door and one outside the door. R23 stated they had to use a lot of blankets to keep warm. During interview on 1/9/13, at 2:10 p.m., R12 stated room was "too cold." Observations at that time revealed R12 dressed in long sleeves. On 1/8/13, at 8:00 p.m. R32 was observed in room sitting in a wheelchair fully clothed, wrapped with a fleece blanket. R32 stated she was always	F 257		

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F 257	Continued From page 12 cold in her room. During the environment tour on 1/9/13, at 2:10 p.m., the maintenance supervisor verified the north end of the east wing was cold. He stated the basement located under the east wing was not heated and that makes it harder to heat the wing. He stated they had turned on the heat in the basement last night however, there was a "stuck zone valve" and this stopped the heating of the basement. During interview at that time, the maintenance supervisor stated he was aware of cold resident rooms. Maintenance supervisor stated he had replaced 3 different pumps, repaired the door heater above the exit door outside of room 214, and last week he replaced the thermostat in room 214. He verified the new thermostat in room 214 regulated the heat in rooms 210, 211, 212, 213, and 214. During interview at that time, the maintenance supervisor verified the thermostat in room 214 was currently set at 85 degrees Fahrenheit and registered the temperature at 71 degrees. The maintenance supervisor verified although the facility had attempted to repair the cold temperatures, residents still expressed cold temperatures.	F 257		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	See Attachment #6	2/19/13

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F 280	Continued From page 13 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the plan of care for 1 of 3 residents (R22) reviewed for falls; for 2 of 3 residents (R16, R22) reviewed with pain, and for 1 of 1 resident (R35) reviewed for abuse. Findings include: R22 lacked current falls interventions to prevent falls in the care plan. R22 was observed on 1/10/13, at 7:45 a.m. lying in bed with half side rails on each side of the bed. R22 was observed sleeping in bed with his head next to left side rail and feet off edge of the right side of bed. During an interview on 1/10/13, at 7:50 a.m. nursing assistant (NA)-B stated R22 would sometimes lie across the bed. NA-B stated R22 had a large mattress for that reason and the body pillow was under the sheet because R22 would push the pillow off the bed. R22's care plan dated 1/9/13 indicated R22 was at risk for falls. Approaches for fall risk indicated: keep room free of barriers, fall risk assess	F 280		

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F 280	Continued From page 14 quarterly and PRN (as needed), meds as ordered (to include pain meds), notify MD (medical doctor)/family if falls occur, provide adequate light in room, observe for side effects of medications, call light within reach, refer to mobility plan, refer to toileting plan, two staff assist with Hoyer (mechanical lift) for transfers, redirect resident and remind not to self-transfer, and body pillow left/right side when in bed. The care plan lacked the use of side rails, lacked the use of the oversized mattress, lacked directions to place body pillow to prevent resident from kicking off or laying on top of pillow, and lacked directions related to need to monitor and reposition when laying crosswise in bed. During an interview on 1/10/13, 9:12 a.m. the registered nurse (RN)-B, nurse manager stated she was monitoring R22, but had not revised the care plan. R16 lacked care plan revision for pain. During interview and observation on 1/7/13, at 12:15 p.m. R16 said they had left hip pain and was observed at the time to rub the left hip. During an interview on 1/10/13, at 8.00 a.m. licensed practical nurse (LPN)-B stated R16 was experiencing pain in the left hip and was given as needed (PRN) Ultram prior to the shower so R16 could walk to the shower. R16's care plan dated 11/27/12, indicated potential for pain related to cellulitis and poorly healing diabetic wounds. The problem did not identify the left hip pain. Interventions included pain medications per physician order, pain	F 280		

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F 280	Continued From page 15 assessment quarterly, update MD/NP/family of any increased complaints of pain, and call light within reach. The care plan did not include non-pharmacological interventions or use of PRN medications to assist the resident to manage day with minimal pain. During an interview on 1/10/13, at noon, RN-A verified no non-pharmacological interventions were listed on care plan and R16's care plan did not include interventions for chronic hip pain. R22's care plan for pain management did not include a concern related to left heel pain and it did not include interventions to assist R22 to manage the heel pain. The care plan problem for pain management dated 11/6/12 indicated R22 had no complaints of pain. Interventions directed staff to provide pain medications as ordered, assess pain quarterly, notify MD and family if significant change or increase in pain, encourage activity, restorative nursing, monitor for side effect of pain medication, update family of any new pain medications, use non-medication interventions such as repositioning, distraction, encourage activities outside of room, and encourage to call family. During observation and interview on 1/8/13, at 3:45 p.m. R22 stated they had pain in the right foot as a result of a fractured heel sustained during a fall. Review of documentation dated 12/8/12 through 12/31/12 indicated R22 had attempted to stand on three occasions prior to the fall on 1/1/13.	F 280		

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F 280	Continued From page 16 During an interview on 1/9/13, at 2:15 p.m. the director of nursing (DON) indicated revision of the care plan following previous attempts to stand had been missed. During an interview on 1/10/13, RN-B stated she had not updated the care plan for R22 after he fell and fractured the heel. R35 lacked the revision of the plan of care to include the potential emotional and psychological abuse by family members. R35's care plan dated 1/10/13 identified the problem of " Abuse Prevention Plan: Resident is a vulnerable adult." The care plan did not identify any issues related to family interactions that were " possible emotional/psychological abuse towards resident." R35 was admitted to the facility 11/16/12. Review of the interdisciplinary team notes indicated staff observations and concerns related to family to resident interactions. A social service note dated 12/3/12, indicated the licensed social worker ((LSW) was aware of the concerns and documented, "staff have voiced concerns regarding resident's family and possible emotional/psychological abuse towards resident." During an interview on 1/10/13, at 2:00 p.m. the DON indicated she was aware of the concerns related to R35. During an interview on 1/10/13, at 2:45 p.m. the LSW indicated she was also aware of these concerns. During an interview on 1/10/13, at 3:45 p.m. both RN-A and RN-B stated they were aware of the concerns related to R35	F 280		

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F 280	Continued From page 17 and the family. Even though the staff were aware of the dysfunctional family dynamics and allegations of abuse the care plan had not been up-dated to include interventions to prevent abuse protect R35 right to make choices.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a temporary plan of care to assist staff to manage resident behaviors for 1 of 2 residents (R60) with temporary care plans. Findings include: R60 was admitted to the facility 12/26/12, and had diagnoses that included, but not limited to dementia with behavioral disturbances. Review of interdisciplinary team notes since R60's admission indicated combative behaviors, throwing food, increased restlessness, anxiety, resistive with cares, pinching, and grabbing at staff for which as needed antipsychotic medication was given. The temporary care plan provided 1/10/13, did not include a problem/need related to behaviors or approaches to direct staff to meet R60's needs safely during the display of behaviors. During an interview on 1/10/13, at 2:00 p.m. the	F 281	See Attachment #7	2/19/13

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F 281	Continued From page 18 director of nursing (DON) verified R60's care plan related to behaviors was not addressed on the temporary plan of care.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess a resident's pain and increased use of pain medications following a fall for 1 of 3 residents (R22) reviewed for pain. Findings include: R22 experienced increased pain following a fall and fracture on 1/1/13, without reassessment of pain. During observations and interview on 1/8/13, at 3:45 p.m. R22 stated had pain in the right foot. The pain was a result of a fall. R22's left foot and lower leg were observed to be in a cast. On 10/24/12, a fourth quarter pain assessment was completed by the facility and at the time R22 had no complaint of pain and continued to receive Celebrex and as needed Tylenol for chronic pain, but R22 had not needed any Tylenol for three months. The assessment documentation	F 309	See Attachment #8	2/19/13

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F 309	Continued From page 19 indicated R22's pain was caused by chronic renal failure, a history of upper respiratory infections, chronic pain in left hip/shoulder/upper arm, history of urinary tract infection, venous peripheral insufficiency. No further assessments were found nor were there an interdisciplinary note related to left foot pain assessment found or provided. On 1/1/13 following the fall and heel fracture R22 had received new physician orders for Tylenol with codeine (Tylenol #3) to take 1-2 tablets every 6 hours as needed for pain in left foot and heel. R22 received the medication during 1/1/13 to 1/8/13, time period. An interview conducted on 1/10/13, at 9:12 a.m. with the director of nursing (DON) revealed pain assessments were completed on admission, quarterly, with significant change or with a change in pain status. The DON verified the last pain assessment for R22 was found in the interdisciplinary notes dated 10/24/12. During an interview on 1/10/13, registered nurse (RN)-A nurse manager stated she had not completed a pain assessment for R22 since the fall with fracture.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	See Attachment #9	2/19/13

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F 314	Continued From page 20 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete a comprehensive skin assessment when ulcers developed to promote healing and prevent new ulcers from developing for 2 of 2 residents (R18 and R15) in the sample reviewed for skin ulcers. Findings include: R18 had a pressure area on the tip of the left great toe which was not comprehensively assessed for causal factors and preventative interventions developed to promote healing and prevent new ulcers from developing. R18 was admitted in 2010, with diagnoses that including osteoporosis and dementia. R18 was observed in a recliner with his legs elevated, wearing socks but no shoes on 1/7/13, at 3:00 p.m.; 1/8/13, at 2:00 p.m.; 1/9/13, at 10:05 a.m.; and on 1/9/13, at 11:00 a.m. On 1/9/13 and 1/10/13, at 7:05 a.m. R18 was observed wheeling down the hall in the wheelchair wearing tennis shoes. On 1/9/13, at 2:30 p.m. R18 was observed resting in the reclining chair. Licensed practical nurse (LPN)-B went into R18's room for a dressing change at which time R18 ' s left shoe and sock were removed, a sponge dressing was over his left great toe, the top of the left great toe had a very small area of loose skin but only very minute drainage on the old dressing was noted,	F 314		

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F 314	Continued From page 21 LPN-B completed the dressing change. Immediately after the dressing change LPN-B said that she was unsure how the pressure area started, as R18 had it for such a long time, he only walked short distances, used a wheelchair and the area was measured weekly with the bath. Minimum Data Set (MDS) quarterlies dated 5/8/12, 8/7/12 and 11/6/12 were reviewed and no pressure ulcers or foot problems were identified on any of the three. Skin assessment documentation dated 4/12 through 1/13, were reviewed. Initially, a note dated 7/27/12, identified a callus area on tip of left foot great toe that measured 1.2 centimeters (cm) around. A cushion pad was applied to the area. No further assessment of the area was completed to determine the cause or other interventions implemented to reduce and/or prevent further deterioration. On 8/3/12, a note identified a scab on the tip of left foot great toe. Weekly notes continued to identify the scabbed area until a note dated 9/28/12, indicated the callous fell off during the bath. The wound had a thin layer of skin and was moderately pink. A band aide was applied with antibiotic ointment. Weekly notes afterwards identified an intact callous on the tip of the left great toe until 11/23/12, when the callous fell off and the area had a scant amount of clear drainage coming from an open area. The wound measured 0.5 cm around and 0.2 cm deep. The same measurement was noted on 11/30/12. On 12/7/12, 12/21/12, 12/28/12, and 1/5/13, the left tip of the great toe had a dry brown scab 0.5 cm round. None of the notes identified causal factors. The notes identified the treatment but no	F 314		

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F 314	Continued From page 22 further interventions to be used. A physician's note dated 10/26/12, "under wounds or ulcers: apparently there is a wound on the tip of his left great toe. It is an old blister and it is healing." R18's care plan dated 11/20/12, indicated pressure ulcers: potential risk for skin breakdown related to needing assistance with activities of daily living, bed mobility, transfers, limited vision, diagnoses of dermatitis and eczema, chronic pain, HTN (hypertension), hypothyroidism, memory loss, nodular prostate, and anemia. Interventions included: skin treatments per physician's orders, pressure relieve mattress, observe skin daily with cares, tissue tolerance test annually and PRN (as needed), Braden scale quarterly and PRN, podiatrist to see PRN, skin risk factors quarterly and PRN, nursing to check skin weekly on bath day. On 1/10/13, at 2:15 p.m., the director of nursing (DON) was interviewed and stated the initial assessment for the area on the tip of R18's left great toe should have indicated possible cause of pressure area. The DON verified the documentation and assessments did not include possible causes or interventions to use. R18 wore socks all the time and heel boots at night. He also wore shoes. At 3:10 p.m., the DON said she would expect staff, if they found skin issues of any kind to assess it further for cause and develop interventions. The DON verified she could not find an assessment for R18 ' s skin ulcer.	F 314		

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F 314	Continued From page 23 R15 developed a new pressure area on the left foot which had not been comprehensively assessed for causal factors or were interventions developed to reduce or prevent further deterioration and promote healing. R15 was admitted in 7/12, with diagnoses including diabetes and a history of diabetic foot ulcer. The quarterly MDS dated 11/23/12, identified R15 with moderate cognitive impairment, independent in activities of daily living, and was at risk for pressure ulcers. On 1/7/13, at 3:08 p.m., a licensed practical nurse (LPN)-B was interviewed regarding R15's pressure ulcers. LPN-B indicated R15 had an area outside of right phalange joint which the resident had for years and it would come and go. LPN-B also stated R15 had another area on the right heel which was not draining. LPN-B stated the area on the right heel was scabbed over and not stageable. LPN-B stated R15 was going to the wound clinic the following day. During observations on 1/7/13, at 11:15 a.m.; 1/8/13, at 1:00 p.m.; and 1/10/13, at 7:50 a.m., R15 was observed wearing three pair of socks (two gripper socks and a new pair of thick padded socks which came from the wound clinic) when ambulating in the hall or sitting in the room. R15 was not wearing heel protectors when sitting in the room. LPN-B stated R15 refused to wear heel protectors and had an air mattress on the bed. On 1/9/13, at 11:30 a.m. R15 was observed	F 314		

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F 314	Continued From page 24 having a dressing change for pressure ulcers of the right foot completed by LPN-B. It was noted there was an area almost dime sized and scabbed over on the right heel. During the dressing change LPN-B indicated the wounds were measured weekly on bath day. R15's care plan dated 11/13/12, indicated pressure ulcers/skin. R15 received Braden score of 20 indicating low potential for pressure ulcers. Interventions included all the assessments quarterly and annually, daily skin checks with cares, weekly skin checks by nurse, encourage fluids, skin treatments as ordered pressure relieving mattress on bed, and notify of any skin complications. Skin assessment progress notes and wound assessment notes dated 11/26/12 through 1/7/13, were reviewed for R15. The 11/26/12, note identified a new area on the back right heel, dark red colored and measuring 0.3 cm x 0.3 cm and not open. A Mepilex dressing (an absorbent, dressing made from polyurethane foam) was applied for comfort. A note dated 12/3/12, identified the right heel with a 0.4 cm x 0.3 cm callus area tender to touch, but no redness or signs/symptoms of infection. On 12/10/12, the note indicated the wound on the right heel remained unchanged and described the wound as 0.5 cm x 0.3 cm with brown scabbed area in center of the wound, no redness or drainage noted. On 12/16/12, the skin assessment note indicated no areas of concern at the time. On 12/20/12, a note indicated the right heel was red with dark hard core inside, and would be seen at wound clinic. On 12/31/12, a note described the right posterior heel with 0.7 cm x 0.9 cm eschar	F 314		

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F 314	Continued From page 25 (piece of dead tissue) covering the area. The 1/7/13, skin progress note indicated a wound to right heel with an intact scab that measured 0.7 cm and was brown in color, no redness, swelling, or drainage was noted. On 1/10/13, at 2:15 p.m., the DON stated an initial assessment should have been completed to include possible cause of a new open area. The DON verified R15's body audit sheets, skin assessment notes and summaries lacked documentation of possible cause/s of a pressure ulcer , did not address preventative treatments and interventions to be used.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reassess after a fall with injury for 1 of 3 residents (R22) reviewed for falls. Findings include: R22 experienced a fall on 1/1/13 with fracture and no reassessment of fall risk had been completed.	F 323	See Attachment # 10	2/19/13

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F 323	Continued From page 26 During observations and interview on 1/8/13, at 3:45 p.m. R22 stated the leg cast on the left foot and lower leg was the result of a fall. During an interview with licensed practical nurse (LPN)-A on 1/7/13, at 12:00 p.m. LPN-A stated R22 fell on 1/1/13, at 9:30 p.m. and broke the heel. Review of documentation dated 12/8/12 through 12/31/12, indicated resident had attempted to stand on three occasions prior to the fall on 1/1/13. The incident report dated 1/1/13 stated R22 had fallen during an attempt to stand. A fourth quarterly review completed 10/26/12, for fall risk indicated R22's fall risk assessment score was 15 indicating R22 was at high risk for falls. R22 had not fallen since 10/29/11. The review indicated R22 was non-ambulatory and required assist of two staff with a Hoyer (mechanical) lift for all transfers. The review indicated R22 had physical concerns and medication which increased the risk for falls. A reassessment of R22's fall risk following the 1/1/13, fall was not found. During an interview on 1/10/13, registered nurse (RN)-A, nurse manager stated she had not completed a fall assessment following the fall on 1/1/13.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	See Attachment #11	2/19/13

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F 329	Continued From page 27 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify parameters for use of psychoactive medications for 4 of 10 residents (R57, R60, R33, R43) in the sample reviewed for unnecessary medications; failed to consistently monitor effectiveness of as needed psychoactive medication for 1 of 10 residents (R15) in the sample reviewed for unnecessary medications, filed to attempt a dose reduction of an antidepressant medication or provide a physician ' s justification why a dose reduction was contraindicated for 1 of 10 residents (R18) in the sample reviewed for unnecessary medications; failed to justify the continued use of an antidepressant at doses exceeding the manufacturers recommended dose for geriatric residents for 1 of 1 residents (R29) in the sample	F 329		

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F 329	Continued From page 28 reviewed for unnecessary medications. Findings include: R57 had orders for as needed (PRN) Seroquel an antipsychotic medication, however, parameters for its use were not specified, and the efficacy of the medication was not being consistently monitored. R57 was admitted to facility in 12/12 with diagnoses including malignant neoplasm of cerebral meninges and delirium. Current physician orders were for Seroquel 25 milligrams (mg) 1/2-1 tablet every six hours PRN. The physician orders lacked parameters or direction for when to use which dosage. The Medication Administration Record (MAR) from 1/1/13 to 1/9/13 revealed R57 received eight doses of Seroquel 25 mg, and the effectiveness of the medication was inconsistently documented. R57's care plan dated 12/18/12 identified that R57 was at "potential risk of increased delirium r/t [related to] diagnosis of malignant neoplasm of cereral [sic] meninges, delirium " The care plan approaches directed staff to administer medications as ordered, monitor for effectiveness and/or adverse effects from medications. Licensed practical nurse (LPN)-C was interviewed on 1/9/13 at 3:26 p.m. When deciding which dosage to administer, LPN-C stated she would check with staff, check the behavior sheets, and use nursing judgment. LPN-C confirmed the order lacked parameters for use of Seroquel.	F 329		

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F 329	Continued From page 29 The director of nursing (DON) was interviewed on 1/9/13, 3:31 p.m. The DON stated the current order was unacceptable as it needed parameters for use of Seroquel, and it would be expected staff would have clarified the PRN Seroquel order at the time of the resident's admission. In addition, the nurses should have charted the effectiveness of the PRN medication each time it was administered. R60 lack the development of parameters for use of as needed (PRN) antipsychotic medication (Risperdal) and the development of non-pharmacological interventions to assist the staff to minimize the use of the PRN medication. R60 was admitted to the facility on 12/26/12 with diagnoses including dementia with behavioral disturbances. The physician ordered Depakote for unstable mood, Trazodone to promote sleep, and Risperdal for agitation/paranoia and PRN for agitation. The orders did not include direction for symptoms and/or behaviors warranting the use of the PRN medication, nor non-pharmacological interventions to attempt prior to the use of the medication. Although R60's IDT notes revealed the resident was administered PRN Risperdal when displaying combative behaviors, throwing food, (increased) restlessness, anxiety, resisting care, pinching, and grabbing at staff, the documentation did not include non-pharmacological approaches attempted prior to the administration of the antipsychotic medication. R60's temporary care plan (provided 1/10/13) lacked a problem/need related to behaviors as	F 329		

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F 329	Continued From page 30 well as approaches to direct staff to minimize the likelihood the resident would display maladaptive behaviors, and how to safely meet the resident's needs. The use of PRN antipsychotic medication was also not addressed on the care plan, and what interventions staff were to attempt prior to administering additional medication. During an interview on 1/10/13 at 2:00 p.m. the DON verified there were no parameters for use of the as needed Risperdal. R33 lacked parameters for which Ativan (anti-anxiety medication) and Roxanol (pain medications) were to be given. R33 had diagnoses that included, but not limited to: dementia with behavioral disturbance, psychosis, depressive disorder. R33 had physician orders for: Roxanol as needed for pain and Ativan as needed for agitation/anxiety. The Guidelines for Administration of PRN Anti-Anxiety Medications indicated the Ativan was to be given for restlessness, wandering, elopement attempts, unable to redirect. The care plan dated 1/9/13 did not identify the use of the as needed medications, when to give the medications and what non-pharmacological interventions were to be attempted first. Review of nursing notes of 12/15/12 through 1/7/13 indicated R33 had received the Ativan and morphine together for restlessness and behaviors, but the reason the medication was given or the effectiveness of that medication was not always documented. The non-pharmacological interventions attempted	F 329		

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F 329	Continued From page 31 prior to the administration of the as needed psychotropic medications was not identified. During an interview on 1/9/13 at 3:10 p.m. the director of nursing indicated that specific symptoms for which the Ativan and Roxanol to be given were not identified. R43 lacked parameters for PRN use of Ativan R43's current physician orders included hospice services to include Ativan (anti-anxiety medication) 0.5 mg 1-2 tablets every four hours PRN, however, parameters for use and the efficacy of the medication was inconsistently monitored. The MAR for 12/12 to 1/7/12 revealed the resident was administered eight doses of Ativan was administered, but the number of tablets administered was not documented, nor was the effectiveness consistently noted. R43's care plan (reviewed 1/7/13) identified, "Comfort Care: Hospice" with approaches including "comfort packet of medications," and to contact hospice/MD[medical doctor]/CNP[certified nurse practitioner] with any concerns regarding change in condition, medications, family, acute conditions and upon death. Licensed practical nurse (LPN)-B explained in an interview on 1/10/13, at 12:11 p.m. that the dose of ativan administered depended on R43's agitation level. The DON verified in an interview on 1/10/13, at 12:38 p.m. that parameters for the use of the Ativan PRN were not noted, and she would have someone clarify the order. She also stated that the nurses should have been documenting the	F 329		

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F 329	Continued From page 32 effectiveness each time PRN medication/s had been administered. R15 was prescribed Celexa 10 mg daily, however, an mood monitoring was lacking to show the efficacy of the medication. Readmission notes dated 10/9/12 and 11/16/12 revealed R15 was receiving Celexa for depression, but did not note the effectiveness the medication may have had on the resident's mood. The DON explained on 1/10/13, at 11:20 a.m. that staff recorded the resident's behavior, and reviewed the documentation with the NP and nurses made quarterly notes regarding psychotropic medication use. The documentation, however, simply noted the medication the resident was prescribed, and was lacking an analysis of the resident's mood. The DON stated, "We need to go a step further" in regards to identifying if the medication was effective. On 1/10/13 at 2:15 p.m. the consultant pharmacist was interviewed via telephone. He indicated parameters for the use of PRN medication should at minimum include a diagnosis, but ideally would also include the symptoms that constituted the use of the medication. Staff should have been documenting symptoms a resident displayed that warranted the use of the PRN medication. In addition, federal regulation required dose reductions in an antidepressant should have been attempted twice in the first year, and at the very least, documentation why no changes were made. After the first year, reductions should have been considered annually.	F 329		

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F 329	Continued From page 33	F 329		

R18 had physician's orders for Celexa 10 mg daily ordered 12/12/11 for depression, however, a dose reduction was not attempted or rationale for continued use of the medication was documented since it had been ordered.

R18 was admitted in 2010 with diagnoses including dementia and depression.

R18's nurse reactionary (NP) noted no depressive symptoms according to progress notes dated 4/12/12 and 8/16/12. Physician progress notes 6/26/12 and 10/26/12 identified the resident was prescribed Celexa, however, did not address the effectiveness and continued need for the medication.

R18's most recent quarterly summary by a nurse dated 11/8/12 revealed, "Psychotropic Medications: Resident receives Celexa daily for depression and Trazodone every HS [hour of sleep] for insomnia." No further documentation was made regarding the efficacy of the medication. Daily target/mood behavior monitoring was documented, however, a summary as to whether the Celexa was determined to be effective and/or for the continued need was not noted, and a rationale for the continued use was not noted by the practitioner.

The DON was interviewed regarding R18's antidepressant medication on 1/10/13, at 11:20 a.m. She stated that although the resident was not displaying any signs of depression, she continued on the same dose of the medication for

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F 329	Continued From page 34 the past year. Nurses were responsible for completing quarterly summaries that included a review of psychotropic medication, and the DON verified R18's summaries only noted the medication the resident was receiving, and not an analysis as to the need for continued use of the medication. The DON said the nurse practitioner (NP) addressed the use of the Celexa in a note dated 8/12, but was unsure why it was not again addressed during the visit in 12/12. She verified the physician had not made notes justifying the continued use of the medication during visits to R18. R29's record lacked documentation of a clinical rationale for ongoing use of Celexa in dosages that exceeded manufacturer's recommendations. R29 had diagnoses including major depression, and the physician prescribed the antidepressants Wellbutrin 100 mg twice daily (start date 7/18/11) and Celexa 30 mg daily (start date 7/18/11). A Consultant Pharmacist Review dated 8/22/12 indicated the Celexa dose was in excess of maximum recommended dose of 20 mg per day for patients over age 60, and there had been no recent attempts to reduce the use of Wellbutrin. On 1/24/12 the psychiatrist noted the resident was stable on the current antidepressant and he would not recommend changing the dosing. On 8/22/12 the nurse practitioner documented, "No reduction, no change, extensive psychiatric history, current stable. Benefit of current therapy ongoing risk of depression/anxiety exacerbation." The DON stated on 1/9/13 at 2:40 p.m. that the	F 329		

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F 329	Continued From page 35 continued use of the antidepressant medications and excessive dosage of Celexa had not been addressed by the physician. The DON added that there was no documentation to support the rationale for ongoing use of the medications at the current doses. The care plan for R29 dated 1/9/13 was reviewed. The care plan had identified problems of mood state and of behavioral symptoms, but lacked approaches and non-pharmacological interventions to be used by staff to assist the resident.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request,	F 356	See Attachment #12	2/19/13

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F 356	Continued From page 36 make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post required staffing information that included facility name, census, and total hours worked. This had the potential to affect all 39 residents. Findings include: On 1/7/13, at 9:15 a.m. the receptionist posted the facility staffing information. The information identified facility census as 38 with one resident hospitalized. The staffing information included all three shifts, licensed and unlicensed staff, and shift hours worked. Observations at that time revealed the staffing information did not include the current census, facility name, and total hours worked for each discipline. During interview on 1/7/13, at 10:05 a.m. the director of nursing (DON) verified the facility census was currently 39 with 1 resident in the hospital. The DON verified the staffing information posted with census of 38 was incorrect. The staffing hours did not include total hours worked for each discipline. Observations during the initial facility tour on 1/7/13, at 9:15 a.m.	F 356		

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F 356	Continued From page 37 revealed the staffing information posted included all three shifts and actual shift hours worked. The staffing information did not include total hours worked for each discipline. During interview on 1/8/13, at 1:45 p.m. the DON verified the staffing information posted did not include facility name and total hours worked for each discipline.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their	F 441	See Attachment #13	2/19/13

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F 441	Continued From page 38 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a multi-resident use blood glucose monitor had been sanitized after use for 1 of 2 residents (R29) in the sample who had a blood glucose test completed. Findings include: R29 had a blood glucose test done and after the procedure the multi-resident monitor had not been sanitized before storage for future use. The resident had diagnoses including diabetes mellitus, and the physician ordered (dated 9/6/12) blood sugar four times a day. R29's blood sugar check was observed on 1/9/13, at 11:30 a.m., by a licensed practical nurse (LPN)-A using an Assure-Pro glucometer. The LPN washed hands, donned gloves, obtained the blood sample with the lancet, and then placed it onto a test strip located in the glucometer. The test strip end of the glucometer was wiped with an alcohol wipe, and the glucometer was then placed in a drawer of the	F 441		

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F 441	Continued From page 39 medication cart. After the observation, the LPN explained that this glucometer was used for three residents on the west wing. The LPN verified the glucometer should have been sanitized using a Super-Sani-wipe, which is an Environmental Protection Agency (EPA) approved sanitizer to prevent the spread of blood infection/disease. The director of nursing (DON) stated on 1/9/13, at 5:50 p.m. she expected staff to sanitize the glucometers using the Sani-wipes after each resident use. The facility Blood Glucose Monitoring policy dated 5/17/12, directed staff to, "Clean glucometer machine with disinfectant wipe and let it dry for 1 minute before returning to drawer."	F 441		

Attachment 1

Regulation 483.10(b)(5) Tag F156
Notice of Rights and Services

The goal of Kenyon Sunset Home is to assure that each resident knows his or her rights and responsibilities and that the facility communicates this information prior to or upon admission, as appropriate during the resident's stay. The facility routinely notifies the resident/family before Medicare benefits are discontinued and provides the resident/legal representative with a timely notice of payment liability and of the right to submit a demand bill and have an independent review of the facility's decision to deny benefits.

The procedures for resident/legal representative notification of reduction or discontinuation of Medicare benefits were reviewed and revised. All residents/legal representatives, including those who are being discharged, will now be provided information regarding their right to an expedited review of the Medicare denial decision. Residents who are not planning to leave the facility and their family/legal representative will continue to be provided with and requested to sign 1) an Advanced Beneficiary Notice explaining the reduction or discontinuation of Medicare benefits, payment liability, and the right to a demand bill submitted and 2) the Notice of Medicare Provider Non-Coverage which informs them of the right to an expedited appeal by the Quality Improvement Organization of the decision to discontinue Medicare benefits. If the resident/legal representative is unable/ unavailable to receive/sign the required notices, the notifications are sent by certified mail. To verify that the liability and appeal notices have been provided, copies of the signed forms are kept on file at the facility.

The staff responsible for issuing notices related to reduction or denial of Medicare benefits have been educated on the revised procedures for providing the required notices. In the future, residents receiving a Medicare qualifying skilled service will receive the notice of the right to appeal the Medicare decision regardless of their plans for discharge.

Residents number 13 (discharged to home 9/21/12) and number 53 (discharged to home 9/7/12), were admitted from the hospital for short-term rehabilitation services. The residents met their rehabilitation goals and returned home as planned. Both residents were anticipating discharge, neither resident expressed any concerns regarding the Medicare eligibility or discontinuation of Medicare benefits.

The Director of Nursing/designee will be responsible for monitoring compliance with Medicare notification requirements. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Completion Date: February 19, 2013

Attachment 2

Regulation 483.10(f)(2) Tag F166
Resident Rights-Grievances

The staff at Kenyon Sunset Home respect the residents' right to autonomy and choice and protect and promote the residents' legal rights as well as their rights to privacy and a dignified existence. The facility encourages the residents to voice grievances and respects their right to prompt staff efforts to resolve grievances including concerns about television reception. The staff will continue to respond to residents' concerns in a timely manner. The residents/families are encouraged to voice concerns during the interdisciplinary care planning conferences.

The policies and procedures for responding to residents' grievances/concerns were reviewed. Additional clarifying information will be added and communicated to the staff. After receiving a complaint/grievance/concern, the facility seeks a resolution in a timely manner and keeps the resident appropriately apprised of the progress toward resolution. The Resident Handbook contains instructions for reporting and facility practices for resolving greivances/concerns. The residents/families are encouraged to voice concerns during the interdisciplinary care conferences.

Resolution of concerns or attempts to resolve concerns (if resolution is not possible) will be documented in the resident's record. Formal grievances will be reported to and monitored by the Quality Assessment and Assurance Committee as appropriate.

During the February 13, 2013 mandatory meeting, the staff will be reminded of 1) the residents' right to report grievances and care concerns 2) the responsibility to communicate resident concerns to the appropriate agency/supervisory staff in a timely manner and 3) the procedures for reporting grievances/concerns.

The Mediacom cable company was notified of the problems with television reception and the sound and picture were restored January 9, 2013. When interviewed by the social worker February 4, 2013 regarding her satisfaction with television function, resident number 11 stated, "they are all working and all have sound."

The Social Worker will monitor compliance by asking members of the Resident Council for feedback regarding concerns about their environment and promptness of the facility's response to grievances. During the quarterly interdisciplinary care conference, the residents/families will continue to be asked about concerns regarding cares or other issues and their satisfaction with the facility's response to their concerns. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Date of Completion: February 19, 2013

Attachment 3

Regulation 483.13(c)(1) Tag F225
Staff Treatment of Residents

Kenyon Sunset Home policy requires that all alleged violations involving resident mistreatment, neglect, abuse, injuries of unknown source and misappropriation of property be 1) reported immediately to the administrator and appropriate state agencies and 2) thoroughly investigated in a timely manner with the investigative results reported to the administrative staff and state officials as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process.

The facility's policies and procedures for investigation/reporting of incidents were reviewed with minor revisions to improve clarity. During the mandatory meeting February 13, 2013, the staff will be instructed on the following: 1) the definition of a vulnerable adult 2) who is a mandated reporter of actual or suspected resident abuse/neglect/misappropriation of property 3) the types of incidents that must be reported to the common entry point and/or the Minnesota Department of Health 4) the requirement for immediate reporting of alleged abuse/neglect and misappropriation of funds to the supervisory/administrative staff and appropriate government agency and 5) the forms and procedures for appropriate and timely reporting. The staff are educated on vulnerable adult issues at least every twelve months; vulnerable adult reporting and investigation are addressed during new employee orientation.

Resident number 35 died at the facility on December 10, 2012. The family-to-resident verbal adult abuse concerns for resident number 35 were identified during the review of records of discharged residents. The resident's husband had been a resident at the facility and the staff was well aware of the family dynamics, personalities, and pattern of verbal interactions. The family-to-resident interactions had been addressed during a nurses' meeting. The family had been counseled by at least two registered nurses on therapeutic interventions and comfort cares related to the resident's anxiety and declining condition. The social worker had called the Ombudsman's office to discuss/report the family's verbalizations and treatment choices. The ombudsman did not return the call. The documentation addressing the family's involvement with cares/verbalizations with the resident and the delays in reporting have been reviewed and are being addressed as part of the facility's ongoing quality improvement program and staff education activities.

The Social Worker will monitor compliance by auditing incident reports and tracking logs for timely and appropriate notification of the administrator and government agencies for the next three months. If noncompliance is noted, additional auditing and training will be done. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting and ongoing.

Completion date: February 19, 2013

Attachment 4

Regulation 483.13(c) Tag F226
Staff Treatment of Residents

Kenyon Sunset Home has developed and implemented written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures address the seven following components: screening, training, prevention, identification, investigation, protection and reporting/response.

Kenyon Sunset Home staff recognize and respect each resident's right to be free from mistreatment and misappropriation of property and does all that is within their control to prevent such occurrences. The staff 1) identifies residents who are at risk for abuse, neglect and/or misappropriation of property as well as those at risk of abusing others 2) develops intervention strategies to prevent occurrences and 3) continually reassesses the effectiveness of the interventions.

The policies and procedures for communicating and reporting alleged mistreatment and misappropriation of resident property were reviewed and revised to reflect immediate reporting to the administrator. The staff responsible for reporting suspected abuse to the state agencies were informed of the policy changes.

Resident number 35 died at the facility on December 12, 2012. The family-to-resident vulnerable adult abuse concerns for resident number 35 were identified during the review of records of discharged residents. The resident's husband had been a resident at the facility and the staff was well aware of the family dynamics, personalities, and pattern of verbal interactions. The family-to-resident interactions had been addressed during several nurses' meetings. The family had been counseled by at least two registered nurses on therapeutic interventions and comfort cares related to the resident's anxiety and declining condition. The social worker had called the Ombudsman's office to discuss/report the family's verbalizations and treatment choices. The ombudsman did not return the call. The documentation addressing the family's involvement with cares/verbalizations with the resident and the delays in reporting have been reviewed and are being addressed as part of the facility's ongoing quality improvement program and staff education activities.

The Social Worker will monitor compliance with the vulnerable adult reporting requirements of the Minnesota Department of Health and outlined in the facility's *Vulnerable Adult/Abuse Prevention Policy* by auditing the vulnerable adult reporting for the next three months. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Completion date: February 19, 2013

Attachment 5

Regulation 483.15(h)(6) Tag F257
Comfortable and Safe Temperature Levels

Kenyon Sunset Home provides a safe, clean, and homelike environment with comfortable temperature levels. The goal is to maintain a temperature range of 71 - 81 degrees Fahrenheit and to be responsive to resident's preferences regarding room temperature.

To improve quality of life for the residents, the facility is undergoing major renovation. Energy efficient windows are being installed to decrease heat loss and provide more even temperatures throughout the facility. Related to the construction and installation of temporary walls and other physical plant modifications, the heat supply was disrupted for a short period of time. Keith Pumper Heating and Plumbing was contacted and has completed furnace repairs.

During the mandatory meeting February 13, 2013, all staff will be instructed to inform their supervisor or the maintenance staff if a resident expresses concern about the temperature of their room or common areas.

Resident number 34 – The resident was discharged home January 17, 2013.

Resident number 25 – The resident has had no recent complaints about her room being too cold. When asked whether her room was cold during the February 4, 2013 interview with the social worker, the resident replied, "No, it is very comfortable." The resident will be asked about her satisfaction with the room temperature during the next visit by the social service staff and at the quarterly care conference.

Resident number 23 – The resident has had no recent complaints about the room being too cold. When asked whether her room was cold during the February 4, 2013 interview with the social worker, the resident replied, "No, it is just fine." The resident will be asked about her satisfaction with the room temperature during the next visit by the social service staff and at the quarterly care conference.

Resident number 12 – The resident has had no recent complaints about the room being too cold. When asked whether her room was cold during the February 4, 2013 interview with the social worker, the resident replied, "No." When asked if the room temperature was comfortable, she replied, "Yes." The resident will be asked about her satisfaction with the room temperature during the next visit by the social service staff and at the quarterly care conference.

Resident number 32 – When interviewed by the social worker February 4, 2013m the resident stated that her room was cool in the day time and cold at night. When interviewed by the administrator February 5, 2013, regarding room temperature, she stated she was comfortable today, but it is cool at night and she uses extra blankets. The administrator measured the room temperature at 73.5 degrees Fahrenheit. The thermostat temperature controlling the resident's room was increased from 75 to 78 degrees. During the February 7, 2013 resident interview by the Director of Nursing, the room thermometer read 73.2 degrees Fahrenheit, the resident was wearing a short sleeved dress and stated she was "comfortable." She reported that the room temperature at night was "much better." A thermometer has been placed in her room allowing her to monitor the temperature.

The resident has hypothyroidism. Thyroid stimulating hormone (TSH) levels have been checked every six weeks for the past three months with changes in the thyroxin dose. The physician/nurse practitioner will be alerted if the resident continues to complain of feeling cold. The care plan has been updated to reflect the resident's complaints of being cold and staff interventions to ensure comfort.

The resident's room is at the end of the hall which tends to be cooler. If the resident continues to feel cold, a room change will be offered after the temporary construction walls are removed. (The resident's special bariatric bed cannot be transported through the narrow halls in the construction area.)

To monitor compliance, temperatures in various resident rooms and common areas will be monitored at least five times per week by the maintenance staff until April 1, 2013. Temperature adjustments will be made if residents complain of being cold or if the air temperature is not between 71 and 81 degrees Fahrenheit. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Completion Date: February 19, 2013

Attachment 6

Regulation 483.20 (d)(3) 483.10(k)(2) Tag F280
Comprehensive Care Plans

Kenyon Sunset Home staff routinely develop comprehensive care plans within seven days after the completion of the comprehensive assessment. Care plans are prepared by an interdisciplinary team, which includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff. Professional disciplines work together to plan and provide necessary services to enhance the residents' functional abilities and quality of life. The residents and their family/legal representative are encouraged to participate in the care planning process and care conferences to the greatest extent possible. Care plans are routinely reviewed and revised by a team of qualified persons after each quarterly assessment and more often as necessary.

During the mandatory meeting February 13, 2013, the nursing staff will be reminded of the requirement that the residents' care plans be current at all times and reinstructed on the facility policies for care plan reviews and updates.

Resident number 22 – The resident has had no falls since January 1, 2013. The resident's safety interventions were reassessed and found to be appropriate. The care plan has been updated to reflect use of side rails, use of an oversize mattress, the placement of a body pillow under the sheet to prevent dislodging and laying on the pillow as well as monitoring the resident's position and repositioning when found laying crosswise in the bed.

The resident can accurately and consistently communicate symptoms of pain. The resident's pain management program/interventions were reassessed by a registered nurse and found appropriate. The resident's pain was also evaluated January 31, 2013 as part of the quarterly assessment. In the five days prior to the assessment, the resident reported rare occurrences of mild pain that did not impact sleep or day-to-day activities. The care plan has been updated to reflect left heel pain with interventions to manage the heel pain to the greatest extent possible. The plan of care addresses nonpharmacological interventions including repositioning, elevating right lower leg, massage, and offering ice packs.

Resident number 16 – The resident can accurately and consistently communicate symptoms of pain. The resident's pain level and impact on sleep/daily activities are currently being evaluated as part of the routine quarterly assessment. The resident's care plan has been updated to include left hip pain with interventions of analgesics as needed/requested to maximize the ability to walk and perform other daily activities. Nonpharmacogical interventions to promote comfort such as repositioning are addressed. The resident often refuses heat or ice packs for pain relief.

Resident number 35 – The resident died at the facility December 10, 2012. The risk of negative emotional/psychological impact from family-to-resident verbal interactions were identified during the review of records of discharged residents. The need for the plan of care to address the dysfunctional family dynamics, allegations of abuse, and the resident's right to make choices has been reviewed and is being addressed as part of the facility's ongoing quality improvement program and staff education activities.

The interdisciplinary team reviews care plans quarterly for completeness, accuracy, and relevancy. In addition, the MDS Coordinator/Director of Nursing/designee will monitor care plan accuracy of three residents weekly for four weeks. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Completion date: February 19, 2013

Attachment 7

Regulation 483.20(k)(3)(l) Tag F281
Services Provided Meet Professional Standards

Kenyon Sunset Home provides or arranges for resident cares and services by appropriate qualified persons that meet accepted practice standards for quality.

The procedures for addressing problematic behavior symptoms that are present at or soon after admission and before the development of the interdisciplinary care plan were reviewed. A designated space to document behavior symptoms, behavior management goals, and staff interventions has been added to the *Initial Interdisciplinary Care Plan* form.

During the mandatory February 19, 2013 meeting, the nursing staff will be instructed on the revisions to the *Initial Interdisciplinary Care Plan* form and the importance of early identification and management of problematic behavior symptoms.

Resident number 60 was admitted December 26, 2012 and transferred to a facility closer to his home January 7, 2013 (11-day stay). The need for the initial care plan to address problematic behaviors was identified during a record audit of discharged residents. The issue has been reviewed and is being addressed as part of the facility's ongoing quality improvement program and staff education activities.

The *Initial Interdisciplinary Care Plan* form will be audited for completeness by the MDS Coordinator/designee. The initial care plans for residents admitted during the next month will be reviewed. If noncompliance is noted, additional auditing and staff training will be done.

Completion date: February 19, 2013

Attachment 8

Regulation 483.25 Tag F309
Quality of Care Tag

Kenyon Sunset Home provides each resident with the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive plan of care. The interdisciplinary care team assesses each resident at the time of admission, quarterly, with significant changes in condition, and more often as the resident's condition indicates.

The facility's pain management policies, and procedures related to completing pain assessments, notifying the physician of pain symptoms/complaints, monitoring the effectiveness of pain management programs, and noting related treatment changes in the resident's plan of care were reviewed. The facility will continue with the practice of completing a pain evaluation for each resident at the time of admission, readmission, every three months, the start of an analgesic, and with significant changes in condition.

During the February 10, 2013 mandatory meeting, the nursing staff will be instructed on 1) the importance of assessing pain intensity and frequency especially after residents experience an accident/incident or other event that would increase their risk of pain 2) implementing effective pain management interventions and 3) documenting the resident's response to the interventions.

Resident number 22 – The resident can accurately and consistently communicate symptoms of pain. The resident's pain management program/interventions were reassessed by a registered nurse and found appropriate. The nurses' entries from January 1 through February 5, 2013 were reviewed; the notes indicate no complaints of pain. The resident's pain was also evaluated January 31, 2013 as part of the quarterly assessment. In the five days prior to the assessment, the resident reported rare occurrences of mild pain that did not impact sleep or day-to-day activities. The care plan has been updated to reflect left heel pain with interventions to manage the heel pain to the greatest extent possible. The plan of care addresses nonpharmacological interventions including repositioning, elevating right lower leg, massage, and offering ice packs.

The nurse manager will monitor compliance with the pain assessments and related documentation through random record reviews for one month. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Completion Date: February 19, 2013

Attachment 9

Regulation 483.25(c) Tag F314
Prevent/Heal Pressure Sores

Based on the comprehensive assessment, Kenyon Sunset Home, ensures that residents who enter the facility without pressure sores do not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable. Residents receive necessary treatment and services to promote healing, prevent infection, and prevent new pressure areas from developing.

The policies and procedures for comprehensively assessing the residents' skin condition and risk factors were reviewed and found appropriate. The routine evaluation of the resident's skin condition, skin risk factors, and tissue tolerance will continue, as well as the weekly skin observations completed by a licensed nurse for residents who have open skin lesions.

Based on the comprehensive skin assessment, care plans are developed to address and minimize risks of skin breakdown. The plans focus on services that maintain skin integrity, prevent pressure sores, and provide treatment as prescribed. The direct care staff routinely inform the charge nurse of any skin problems noted during cares. Observation of skin on all areas of the body is part of the bathing protocol.

The following procedures for completing of the comprehensive skin assessment were reviewed with the licensed nurses: 1) visual inspection of the residents' skin upon admission and readmission from the hospital with documentation of the results 2) completion of a tissue tolerance evaluation and the Skin Risk Assessment with Braden Scale 3) documenting an assessment/analysis of the data from the tissue tolerance evaluation and the Skin Risk/Bradens Scale tools which drives the plan of care 4) development of the skin care plan with interventions based on the comprehensive assessment/analysis and 6) timely revision of the care plan as necessary.

Resident number 18 – The 94-year-old resident was admitted to the facility October 29, 2010. Diagnoses include peripheral vascular disease, chronic obstructive lung disease stage three chronic kidney disease, psychosis, and depressive disorder. The resident's left great toe was reassessed by a registered nurse February 7, 2013. A 0.2 cm x 0.3 cm dark callused area was noted slightly under the tip of the left great toe. There was no sign of infection and the resident denied pain in the area. The resident prefers to wear thick socks with shoes all day. The resident was informed of the risks of wearing thick socks and shoes for an extended time; however, he adamantly refuses to consider different footwear or to remove his shoes or socks during the day.

The podiatrist assessed the resident's toe January 16, 2013 and noted "evidence of symptomatic hyperkeratonic tissue present at L1." The callus will continue to be monitored weekly. Any worsening of the callused area will be reported to the physician and/or the podiatrist. The care plan was reviewed and updated accordingly.

Resident number 15 – The 91-year-old resident was admitted July 24, 2012 and has had two interim hospitalizations due to exacerbation of congestive heart failure. Other diagnoses include history of poorly controlled diabetes, chronic hypoxic respiratory failure and pulmonary hypertension. The resident was seen at the Mayo Wound Clinic January 8, 2013. The report stated, "Pressure may indeed have been an inciting factor on the wounds on the right side, but I believe she has signs of significant distal ischemia on examination which is contributing to her pain and poor healing. Options for management are somewhat limited in this frail, elderly patient, and my inclination would be to start the patient on the ArterialFlow pump rather than proceeding with more invasive vascular evaluation." A registered nurse most recently reassessed the resident's wounds on January 14, 21, and 28, 2013. The resident's wounds will continue to be assessed weekly by the nursing staff. Any significant changes will be reported to the physician/nurse practitioner. The care plan skin-related interventions have been reviewed and revised.

Compliance will be monitored by the Director of Nurses/designee through random audits of the skin assessments and care plans. Compliance will be reviewed at monthly and quarterly Quality Council meetings.

Completion date: February 19, 2013

Attachment 10

483.25 (h) Tag F323
Accidents

Kenyon Sunset Home ensures that the residents' environment remains safe and as free of accident hazards as possible. The facility identifies each resident at risk for accidents and develops a plan of care addressing safety issues and implements procedures to prevent accidents and incidents.

The use of and need for safety devices and other safety interventions are assessed at admission and reassessed during the interdisciplinary care planning conferences and whenever there is a change in the resident's behavior, physical condition, and/or mental function. The resident's care plan is modified as necessary to assure maximum safety and minimal risk of injury.

The policies and procedures related to follow up to falls were reviewed and found appropriate. The policy includes completion of a fall risk assessment after each fall. During the interdisciplinary team meetings Monday through Friday and the weekly Medicare/ therapy meetings, the circumstances surrounding falls are reviewed, causal factors are investigated (need to toilet, pain, medication side effects, hunger/thirst, acute illnesses, etc.), the appropriateness and effectiveness of current safety interventions are reassessed, and the need for additional interventions is evaluated. Care plans are updated as necessary.

Resident number 22 – The circumstances and causal factors of the resident's January 1, 2013 fall were investigated by the interdisciplinary team January 7, 2013. A fall risk assessment was completed by a registered nurse January 10, 2013. The resident had multiple attempts of unsafe independent transfers which started after the discontinuation of Zoloft November 23, 2012. Zoloft was reordered January 3, 2013. There have been no recent attempts to transfer independently and no further falls. The safety plan of care was reviewed and found appropriate.

The Director of Nurses/designee will monitor compliance for the next 30 days through review of all fall incident reports to assure a related fall risk assessment was completed according to facility policy. If noncompliance is noted, additional monitoring and staff training will be done. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Completion date: February 19, 2013

Attachment 11

483.25(l) Tag F329
Unnecessary Drugs

Kenyon Sunset Home staff ensure that each resident's drug regime is free from unnecessary drugs. The resident's drug regime is reviewed by the staff, physician and consultant pharmacist to assure that medications are not used in excessive doses, for excessive duration, without adequate monitoring, without adequate indications, or in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued. An effort is made to identify the lowest effective dose of psychotropic medications and to discontinue the use of psychotropic medications whenever possible.

Based on the resident's comprehensive assessment, Kenyon Sunset Home staff routinely identify target behaviors that justify the use of psychotropic medications and develop guidelines/parameters for medications prescribed on an as needed (PRN) basis. An effort is made to simplify medication regimens and discontinue psychotropic medications whenever possible. Medications are reviewed by the consultant pharmacist monthly and by the attending physician/nurse practitioner during routine 30/60 day visits and more often as indicated.

At the time of the quarterly care conference and more often if needed, residents receiving psychotropic medications are reassessed by licenses nurses and the social worker. The medication type/dose, behavior/mood symptoms, and other related information are reviewed to assure that the record continues to reflect adequate indications for use and that the dose tapering attempts are in compliance with regulatory guidelines. The *Daily Behavior Observation* log is used to identify and quantify target behaviors justifying psychotropic medication use.

A registered nurse will review 1) the records of all residents receiving PRN psychotropic medications to assure that there are guidelines for administration and nonpharmacological interventions as appropriate and 2) the records of all residents receiving antidepressants to assure that mood/behaviors are being monitored daily and the data is summarized on at least a quarterly basis. The use of psychotropic medications will continue to be reviewed with the physicians/nurse practitioners during their routine 30/60 day visits.

During the mandatory meeting February 13, 2013, the nursing staff will be instructed on the use of the behavior monitoring flow sheets and on the importance of identifying and documenting the resident's target behaviors and mood symptoms that justify psychotropic medications. The importance of documenting the resident's response to a PRN medication will be stressed.

Resident number 57 – The resident was admitted December 18, 2012. Diagnoses include cerebral vascular accident, aphasia, malignant neoplasm of cerebral meninges and delirium. Due to escalating target behaviors, the resident's Seroquel dose has been increased to 25 mg. three times per day with an as needed (PRN) dose at night. Target behaviors justifying use of the medication have been identified and are tracked on a daily basis. Guidelines and parameters for administering the PRN dose and nonpharmacological interventions have been communicated to the nursing staff. The care plan has been reviewed and revised. The physician/nurse practitioner will continue to be updated on the effectiveness of the medication as well as the frequency and intensity of the resident's behaviors symptoms.

Resident number 60 – The resident was admitted December 26, 2012 and transferred to a facility closer to his home January 7, 2013 (11-day stay). The need for the initial care plan to address problematic behaviors was identified during a record audit of discharged residents. The issue has been reviewed and is being addressed as part of the facility's ongoing quality improvement program and staff education activities.

Resident number 33 – The 98-year-old resident was admitted December 19, 2008. Diagnoses include dementia with behavioral disturbances, psychosis, hearing loss, and depressive disorder. The resident's care plan and the medication administration record have been updated to include nonpharmacological interventions and specific symptoms/ parameters for administration of the PRN Roxanol and Ativan. The physician/nurse practitioner will continue to be updated on effectiveness of the resident's pain management program and the frequency and intensity of the resident's behavior symptoms.

Resident number 43 – The 83-year-old resident was admitted January 4, 2011. Diagnoses include dementia with behavioral disturbance, psychosis, hypertension, diabetes, and depression. The resident is receiving hospice services and comfort care. The hospice agency staff ordered a variable dose of Ativan without parameters for administration. The order was reviewed by the nurse practitioner February 7, 2013 and changed to Ativan 0.5 mg. every four hours as needed for agitation. Guidelines for administration of Ativan and nonpharmacological interventions for behavior symptoms have been developed and communicated to the staff. The care plan has been updated accordingly. The physician/ nurse practitioner will continue to be updated on the effectiveness of the medication as well as the frequency and intensity of the resident's behaviors symptoms.

Resident number 15 – The resident was admitted July 24, 2012. Diagnoses include depression, congestive and pulmonary heart failure, diabetes and atrial fibrillation. The physician ordered Celexa 10 mg. tablet daily on August 2, 2012 due to the results of the depression screen (PHQ-9) showing the resident was "feeling down/ depressed/hopeless nearly every day" and "with thoughts that she would be better off dead."

The resident's antidepressant use and mood/behaviors were reassessed by an RN February 8, 2013. The Celexa dose was increased to liquid Celexa 15 mg. daily January 10, 2012. A depression screen was repeated January 30, 2013 which showed no indicators of depressed mood on the PHQ-9 screen but the mood/behavior tracking log showed that the resident was isolating herself in her room, making negative statements and refusing cares. The resident's antidepressant medication and mood will be discussed with the nurse practitioner at her next visit with the goal to reduce the antidepressant medication. The care plan has been reviewed and revised.

Resident number 18 – The resident was admitted October 29, 2010 with dementia and depressive disorder with psychosis with a history of electroconvulsant therapy and psychotropic medication use since 1990. Celexa was started November 30, 2010. The resident's mood/behavior and antidepressant use was reassessed by a registered nurse February 8, 2013. The resident's antidepressant medication and mood will be discussed with the nurse practitioner at her next visit with the goal to reduce the antidepressant medication or provide clear justification for the current dose. The care plan has been reviewed and revised.

Resident number 29 – The resident was admitted December 18, 2007 with the diagnoses diabetes, cerebral vascular accident, and major depression previously treated with electroconvulsant therapy. The resident has a long history of receiving multiple psychotropic medications. Celexa and Wellbutrin were ordered July 11, 2012. The resident's Celexa dose was reduced February 7, 2013 with plans to discontinue the medication after one week due to platelet dysfunction. The resident has an appointment with the psychiatrist February 12, 2013. The recent mood/behavior tracking logs will be provided to the psychiatrist with a request to taper/discontinue or clearly justify the current dose of Wellbutin. The care plan has been reviewed and revised.

The Director of Nursing/designee will monitor for adequate documentation and timely evaluations of the appropriateness of psychotropic medications/dosing at least quarterly and more often as necessary. The Director of Nursing/designee and Consultant Pharmacist will monitor compliance with 1) psychotropic medication monitoring 2) appropriate indications for drug therapy 3) appropriate guidelines/parameters for PRN medications. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Completion date: February 19, 2013

Attachment 12

Regulation 483.30(e) Tag F356
Posted Nurse Staffing Information

Kenyon Sunset Home has routinely posted the following information on a daily basis in a prominent location in a clear and readable format:

(i) The current date.

(ii) The number of registered nurses, licensed practical nurses, and certified nursing assistants directly responsible for resident care per shift:

(iii) Resident census.

The posted form has been revised to include the name and location of the facility and total hours worked for each discipline. The posted information will be revised with changes in the daily census. The staff member responsible for posting the staffing information was educated on the revisions.

The Administrator/designee will monitor compliance by randomly checking the posted form to assure that the form includes the facility name and the total number of hours worked for each discipline.

Completion Date: February 19, 2013

Attachment 13

Regulation 483.65(a) Tag F441
Infection Control

Kenyon Sunset Home has established and maintains an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development of disease and infection. The facility has an infection control program that 1) investigates, controls, and prevents infections in the facility 2) determines the appropriate procedures, if any, that will be implemented (such as isolation) for each resident with an infectious disease and 3) maintains a record of incidences of infections and tracks any alternative actions taken related to infection control.

The infection control guidelines on cleaning multiple-resident use glucometers were reviewed and found appropriate. During the February 13, 2013, mandatory meeting, the nurses will be reinstructed on the infection control techniques related to glucometer use. The staff participate in training on infection control techniques at least annually and infection control is included in the new employee orientation program.

The Director of Nursing/designee will monitor compliance through random observations of appropriate staff technique for cleaning glucometers for the next 30 days. If noncompliance is noted, additional auditing and staff training will be done. Compliance will be reviewed during the March 2013 Quality Assessment and Assurance Committee meeting.

Completion Date: February 19, 2013

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

F 5379021

PRINTED: 01/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245379	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/07/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Kenyon Sunset Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	RECEIVED FEB 12 2013 POC ok JP 2-15-13	

Exit: 1.10.13 Dc'd 2.19.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David O. Vander	Administrator	2-8-2013

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 _____	01/07/2013

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

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

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K 000	Continued From page 2 consisting of labeled, self-closing, 90-minute fire rated door assemblies. The facility has a partial fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection in and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 39 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as	K 050		

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K 050	Continued From page 3 required by 2000 NFPA 101, Section 19.7.1.2. The deficient practice could affect all 39 residents. Findings include: On facility tour between 10:30 AM and 12:30 PM on 01/07/2013, the review of the fire drill documentation for the past 8 months (March 2012 to December 2012) revealed, that the 3rd Quarter of 2012, the evening and night shift fire drills were missed. This deficient practice was confirmed by the Facility Maintenance Director (DF) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 050	K050 Kenyon Sunset Home will hold fire drills under varying conditions, at least quarterly on each shift. The planning and coordinating, and filing of documentation proving this has been completed is the responsibility of the Plant Maintenance Department. A separate filing cabinet and shelving area will be established so that all documentation can be placed in a secure location after each drill, and entered into the log books in a timely manner. The nursing home administrator will audit the log book quarterly to insure drills have been completed and logged appropriately. Date certain – Competed as of January 31, 2013	