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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZSO8
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 **03/17/2015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 03/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/26/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/27/2015** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

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

CCN 24-5379

On March 17, 2015, the Minnesota Departments of Health and Department of Health, Office of Health Facility Complaints completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on February 10, 2015 and February 12, 2015. Based on our visit, we have determined that this facility has corrected the deficiencies issued pursuant to our PCR, completed on February 17, 2015, as of March 17, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 17, 2015.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245379

March 26, 2015

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

Dear Ms. Ugland:

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

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

Effective March 6, 2015 the above facility is certified for.

30 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 30 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 24, 2015

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

RE: Project Number S5379024 and H5379012

Dear Ms. Ugland:

On February 23, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 25, 2015. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for survey completed on December 19, 2014, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on February 10, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 17, 2015, the Minnesota Departments of Health and Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on February 10, 2015 and February 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 6, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on February 17, 2015, as of March 17, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 17, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of February 23, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 19, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new

Medicare admissions, effective March 19, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 19, 2015, is to be rescinded.

In our letter of February 23, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 19, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 17, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing	3/17/2015

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 **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**03/05/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**03/05/2015**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	03/24/2015	31221	03/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/19/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZSO8
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 **02/10/2015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

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

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

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

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Gail Sorensen, HFE NE II — Date: 02/26/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Kamala Fiske-Downing, Enforcement Specialist — Date: 03/25/2015 (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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/27/2015** (L33)

DETERMINATION APPROVAL

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

CCN 24-5379

On February 10, 2015, the Minnesota Department of Health and on January 21, 2015, the Minnesota Department of Public Safety completed a revisit to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on December 19, 2014. Based on the visit, we have determined that this facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on December 19, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- Services By Qualified Persons/per Care Plan
F0323 -- S/S: D -- Free Of Accident Hazards/supervision/devices

Refer to the CMS 2567 and the 2567b forms. Post Certification Revisit (PCR) to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

February 23, 2015

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

RE: Project Number S5379024

Dear Ms. Ugland:

On January 12, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an survey, completed on December 19, 2014. This survey found the most serious deficiencies in the facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E).

On February 10, 2015, the Minnesota Department of Health and on January 21, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on December 19, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 23, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our extended survey, completed on December 19, 2014. The deficiencies not corrected are as follows:

F0282 -- S/S: D -- Services By Qualified Persons/per Care Plan
F0323 -- S/S: D -- Free Of Accident Hazards/supervision/devices

The most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective February 25, 2015. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective March 19, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective March 19, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 19, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Kenyon Sunset Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective March 19, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Include electronic acknowledgement signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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 ______	R 02/10/2015

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 An onsite post certification revisit (PCR) was completed on February 9 & 10, 2015. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of this on-site PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained	{F 000}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow its plan of care related to fall prevention for 2 of 3 residents reviewed for falls (R10, R15) Findings include: R10 was observed on 2/9/15, at 2:15 p.m. sitting in a wheelchair positioned with buttocks toward	{F 282}	F282 Kenyon Sunset Home strives to ensure that the services that are provided or arranged by the facility are always provided by qualified persons in accordance with each resident s written plan of care. 1) Our facility s individual resident alarm	3/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/26/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245379	A. BUILDING ______ B. WING ______	R 02/10/2015

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

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

{F 282}

Continued From page 1

the front of the chair seat and feet stretched out in front of him. R10 stated that he wanted to go to bed. It was noted that the bed had a pressure alarm box, but there was none on the wheelchair. The licensed practical nurse (LPN)-A. was interviewed at that time and stated R10 was to have a pressure alarm that would transfer with him from bed to chair and between chairs. LPN-A found the pressure alarm on the floor in front of the recliner. R10 was again observed on 2/10/15, at 9:05 a.m. without the pressure sensor alarm under him while sitting in the wheelchair. Nursing assistant (NA)-A was interviewed at this time. NA-A stated the sensor alarm was to be under him and went to room to verify the placement of the alarm. NA-A asked R10 to transfer to the recliner where the pressure alarm was located.

The significant change Minimum Data Set (MDS) dated 1/6/15, indicated R10 had two falls with injury between 11/25/14 and 1/6/15, and required extensive assist with all activities of daily living (ADL's)

The care plan printed 2/9/15, had an identified problem of falls which directed the use of an alarm in the wheelchair, recliner and bed. The nursing assistant worksheet provided 2/9/15, directed the use of the pressure alarm to recliner, wheelchair and bed at all times and that R10 was a high fall risk.

Review of the Daily Behavior Observations form for 1/15 indicated that between 1/21/15 and 1/31/15, R10 had attempted self-transfers on 5 days.

The director of nursing (DON) was interviewed on

{F 282}

use practices have been reviewed. After research and examining case studies we have determined that our campus will be alarm free as of March 1, 2015. However we are still respecting the wishes of those residents and families that were already utilizing the alarm devices. With this being completed R15 s alarms have been discontinued and her care plan, closet careplan & kardex as well as treatment sheets have all been updated to reflect this. R10 s family has requested the continued use of alarms at this time. To ensure that this deficient practice has been corrected for R10 s alarms have been placed on his bed, recliner and wheelchair. This will eliminate the need to relocate the alarm device when resident is transferred, thus ceasing the deficient practice of not following care plan related to not moving the alarm.

2) With our facility s new practice of no longer utilizing alarm devices there are no other residents that have the potential to be affected by this deficient practice.

3) Our facility has discontinued the use of resident alarm devices. R10 has been grandfathered in to this practice as R10 s family requests the continued use of the alarm device. To ensure that this practice will not reoccur we have placed two additional pressure pad alarms to R10 s room to eliminate the need to transfer one alarm pressure pad when R10 transfers from one surface to another. R10 s pressure pad alarms will be checked to ensure proper function and placement

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 ______	R 02/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 282}	Continued From page 2 2/10/15, at 9:20 a.m. and stated the pressure alarm was to be under R10. R15 was observed on 2/10/15, at 9:10 a.m. sitting in the wheelchair. She was able to move the wheelchair independently. At 10:10 a.m. R15 was observed in bed, bed in low position, mat on floor, and no alarm sensors on the bed. NA- A was interviewed at this time. NA-A stated the NA closet care plan failed to identify the use of a personal alarm in the chair, but did identify to have a bed alarm. The quarterly MDS dated 11/4/14, was reviewed. The MDS indicated no falls during past three months and that R16 required extensive assistance with all transfers and ADL's. The care plan printed 2/10/15, was reviewed. The care plan directed "Tab alarm on at all times to alert staff to unsafe transfers." On 2/10/15 at 3:15 p.m., NA-B and LPN-A were interviewed. They both indicated if a resident had an alarm on the chair it should automatically be placed on the bed also.	{F 282}	each shift by a certified nursing assistant. They will then sign off on the resident s nursing assistant treatment sheet confirming that this was completed. 4)To ensure the completion of R10 s alarm function and placement checks, interdisciplinary team members will take turns completing visual audits of R10 s room, looking for alarm placement and proper functioning, as well as the nursing assistant treatment sheets weekly. 5) Completion date: March 5, 2015	
{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.	{F 323}		3/5/15

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 ______	R 02/10/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure assistive devices to reduce falls were implemented in accordance with the facility assessment and care plan for 2 of 3 residents reviewed for falls (R10, R15) Findings include: R10 was observed on 2/9/15, at 2:15 p.m. sitting in a wheelchair positioned with buttocks toward the front of the chair seat and feet stretched out in front of him. R10 stated that he wanted to go to bed. It was noted that the bed had a pressure alarm box in place, but there was none on the wheelchair. The licensed practical nurse (LPN)-A. was interviewed at that time and stated R10 was supposed to have a pressure alarm in place that would be transfered with him from bed to chair and between chairs. LPN-A found the pressure alarm on the floor in front of the recliner. R10 was again observed on 2/10/15, at 9:05 a.m. without the pressure alarm in place while sitting in the wheelchair. Nursing assistant (NA)-A was interviewed at this time. NA-A verified the sensor alarm was supposed to be in place and went to room to verify the placement of the alarm. NA-A asked R10 to transfer to the recliner where the pressure alarm was located. The significant change Minimum Data Set (MDS) dated 1/6/15, indicated R10 had two falls with injury between 11/25/14 and 1/6/15, and required extensive assist with all activities of daily living (ADL's)	{F 323}	F323 Kenyon Sunset Home strives to ensure that all resident environments remain as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1) Our facility s individual resident alarm use practices have been reviewed. After research and examining case studies we have determined that our campus will be alarm free as of March 1, 2015. However we are still respecting the wishes of those residents and families that were already utilizing the alarm devices. With this being completed R15 s alarms have been discontinued and her care plan, closet careplan & kardex as well as treatment sheets have all been updated to reflect this. R10 s family has requested the continued use of alarms at this time. To ensure that this deficient practice has been corrected for R10 s alarms have been placed on his bed, recliner and wheelchair. This will eliminate the need to relocate the alarm device when resident is transferred, thus ceasing the deficient practice of not following care plan related to not moving the alarm. 2) With our facility s new practice of no longer utilizing alarm devices there are no other residents that have the potential to be affected by this deficient practice. 3) Our facility has discontinued the use of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245379	A. BUILDING ______ B. WING ______	R **02/10/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 4 The care plan printed 2/9/15, identified a problem of falls which directed the use of an alarm in the wheelchair, recliner and bed. The nursing assistant worksheet provided 2/9/15, directed the use of the pressure alarm in the recliner, wheelchair and bed at all times and that R10 was a high fall risk. Review of the Daily Behavior Observations form for 1/15 indicated that between 1/21/15 and 1/31/15, R10 had attempted self-transfers on 5 days. The director of nursing (DON) was interviewed on 2/10/15, at 9:20 a.m. and stated the pressure alarm was to be under R10. R15 was observed on 2/10/15, at 9:10 a.m. sitting in the wheelchair. She was able to move the wheelchair independently. At 10:10 a.m. R15 was observed in bed, bed in low position, mat on floor, and no alarm sensors on the bed. NA- A was interviewed at this time. NA-A stated the NA closet care plan failed to identify the use of a personal alarm in the chair, but did identify to have a bed alarm. The quarterly MDS dated 11/4/14, was reviewed. The MDS indicated no falls during past three months and that R16 required extensive assistance with all transfers and ADL's. The care plan printed 2/10/15, was reviewed. The care plan directed "Tab alarm on at all times to alert staff to unsafe transfers." On 2/10/15 at 3:15 p.m., NA-B and LPN-A were interviewed. They both indicated if a resident had an alarm on the chair it should automatically be	{F 323}	resident alarm devices. R10 has been grandfathered in to this practice as R10 s family requests the continued use of the alarm device. To ensure that this practice will not reoccur we have placed two additional pressure pad alarms to R10 s room to eliminate the need to transfer one alarm pressure pad when R10 transfers from one surface to another. R10 s pressure pad alarms will be checked to ensure proper function and placement each shift by a certified nursing assistant. They will then sign off on the resident s nursing assistant treatment sheet confirming that this was completed. 4)To ensure the completion of R10 s alarm function and placement checks, interdisciplinary team members will take turns completing visual audits of R10 s room, looking for alarm placement and proper functioning, as well as the nursing assistant treatment sheets weekly. 5) Completion date: March 5, 2015	

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 ______	R **02/10/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 5 placed on the bed also.	{F 323}		

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing	2/10/2015

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 F0156 Reg. # 483.10(b)(5) - (10), 483.10(t LSC	01/23/2015	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	01/23/2015	ID Prefix F0226 Reg. # 483.13(c) LSC	01/23/2015
ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	01/23/2015	ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	01/23/2015	ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	01/23/2015
ID Prefix F0309 Reg. # 483.25 LSC	01/23/2015	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	01/23/2015	ID Prefix F0329 Reg. # 483.25(l) LSC	01/23/2015
ID Prefix F0441 Reg. # 483.65 LSC	01/23/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	02/23/2015	19694	02/10/2015
CMS RO				

Followup to Survey Completed on: 12/19/2014

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245379	A. Building B. Wing 01 - MAIN BUILDING 01	1/21/2015

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 Reg. # NFPA 101 LSC K0054	Correction Completed 01/15/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/kfd	02/23/2015	25822	01/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/16/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZSO8
Facility ID: 00145

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/19/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA
02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF
03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC
04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

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

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

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

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

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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	IID
	30			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Marietta Lee, HFE NE II — 01/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 01/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 12, 2015

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

RE: Project Number S5379024

Dear Ms. Ugland:

On December 19, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**
>
> **Informal Dispute Resolution - your right to request an informal reconsideration to dispute the**

attached deficiencies.

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 28, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 28, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 19, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 19, 2015 (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 an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245379	A. BUILDING ______ B. WING ______	12/19/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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	F 156		1/23/15

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

Electronically Signed — 01/20/2015

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

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and 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

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. 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 give at least a two day notice in regards to the change in Medicare services for 1 of 5 residents (R39) reviewed. Findings included: R39 was admitted to the facility on 10/7/14 as found on the face sheet. According to the SNF (skilled nursing facility) Determination on Continued Stay form, the facility determined on 10/13/14 R39's Medicare services would no longer qualify beginning 10/14/14 related to "non-participation in therapy despite numerous attempts at redirecting resident. " The signature of the medical power of attorney on the form indicated the medical power of attorney received notice of non-coverage on 10/20/14.	F 156	F 156 Kenyon Sunset Home strives to ensure that each resident receives and understands his or her rights and rules and regulations governing their conduct and responsibilities during the stay in the facility; which includes but not is limited to information regarding their Medicare covered service(s). 1) Resident R39 has since expired. 2) Residents will be identified as having the potential to be affected by this deficient practice when reviewed for Medicare non-coverage by the interdisciplinary (IDT) team. This review	

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F 156	Continued From page 3 A nursing progress note dated 10/20/14 at 2:01 p.m. authored by the Director of Nursing (DON) indicated the Medicare denial letter was scanned and emailed to medical power of attorney per request. During an interview on 12/17/14 at 5:07 p.m., licensed social worker (LSW)-A verified the date on the form read the facility determined on R39 ' s Medicare services (dated 10/13/14) would end on 10/14/2014. LSW verified a two day notice of Medicare non-coverage was not given.	F 156	will be done upon admission and as needed. 3) The Kenyon Sunset Home Medicare Non-Coverage Notification Policy, which was developed on 1/13/2015, states how Kenyon Sunset Home is to notify residents and/or responsible parties when their Medicare covered service(s) are ending. An administrative officer will notify the resident and/or responsible parties with the Notice of Medicare Non-Coverage and the SNF Determination Letter when determination has been made by the interdisciplinary team. This is to occur upon admission into the facility or during their continued stay. If determination of Medicare non-coverage is made during the resident s continued stay, an administrative officer of Kenyon Sunset Home will notify resident and/or responsible parties no later than 48 hours prior to non-coverage implementation. If advanced 48 hour notice is not attainable due to resident and/or responsible parties request, it will be explained on the Notice of Medicare Non-Coverage and the SNF Determination Letter given to and signed by the resident and/or responsible party. For example, if a resident and/or responsible party elects to begin another Medicare service, i.e. Hospice. A Medicare Non-Coverage Notification Log has been developed to track: resident name, date(s) the Notice of Non-Coverage and SNF Determination Letter was reviewed and signed. 4) A review will be completed by facility	

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F 156	Continued From page 4	F 156	Chief Financial Officer (CFO) weekly for the next 6 months to assure that the proper Medicare non-coverage notices have been provided to the resident and/or responsible party in the required time frame of no less than 48 hours. The results of the review will be reported to the interdisciplinary team weekly for a duration of 6 months and as needed thereafter. This will be reviewed quarterly with the QAA committee. 5) Completion date: January 23, 2015.	
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 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).	F 225		1/23/15

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F 225	Continued From page 5 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 record review, the facility failed to ensure that all alleged violations of neglect were reported immediately to the facility administrator and to the state agency for 1 of 5 residents (R9999) reviewed for abuse prohibition. Findings included: R9999 had an incidents and accidents report dated 3/13/14 that an allegation of neglect had occurred. Licensed practical nurse (LPN)-B made an allegation of neglect that occurred on the evening shift of 3/11/14, however failed to report the incident immediately to the administrator and to the state agency. Facility documentation indicated LPN-B reported to licensed social worker (LSW)-A two days after the alleged incident was reported to her (3/13/14 at 2:30 p.m.) The LSW-A notified the administrator of the allegation on 3/13/14 3:00 p.m. and the director of nursing (DON) at 3:09 p.m. Then filed the initial investigation to the Office of Health Facility Complaints (OHFC) on 3/13/14 at 3:15 p.m. According to the initial complaint investigation,	F 225	F225 Kenyon Sunset Home strives to ensure that each resident s allegation of abuse, neglect, mistreatment or misappropriation of their property is reported immediately to facility Administrator and person in charge. 1) R9999 deceased on March 12, 2014. 2) All Kenyon Sunset Home residents residing in the facility have the potential to be affected by this deficient practice, especially those who are unable to voice their own concerns. 3) Kenyon Sunset Home s Vulnerable Adult/Abuse Prevention Policy has been updated. Kenyon Sunset Home staff has been re-educated on Vulnerable Adult/Abuse Prevention Policy,	

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F 225	Continued From page 6 LPN-B reported the following: At the start of LPN's night shift around 10:00 p.m. on 3/11/14 R9999 was in the dying process (comfort measures were started on 3/7/14). R9999 was found to be poorly positioned and showed signs of air hunger. R9999 oxygen saturations were 70% (Normal oxygen saturations are above 90%). Physician ' s orders indicated R9999 had the following as needed medications available to ease breathing and alleviate discomfort: Morphine concentrate (used to relax breathing and ease pain), Ativan (anti-anxiolytic), and Atropine 1-2 drops (medication to assist with control of secretions). The report indicated a lack of administration of these medications to relieve dying symptoms. R9999 died on 3/12/14 at 4:30 a.m. During an interview on 12/18/14 at 2:30 p.m., LSW-A verified incident was not reported immediately. The LSW-A reported LPN-B who failed to immediately report possible neglect was contracted through a staffing agency. LSW was not aware if the agency nurses received vulnerable adult training and to what extent. LSW stated agency staff members are provided with a brief orientation check list on the first day however policies and procedures for reporting maltreatment, neglect, or abuse were not included on the orientation check list. Facility policy entitled Vulnerable Adult/Abuse Prevention Policy last revised on November 7, 2013 read, "The law stipulates that all employees are mandated reporters of any suspected incidents of maltreatment/neglect. They are to report immediately if: one has knowledge of maltreatment/neglect of a resident, one has reasonable cause to believe that a resident has been maltreated ...if it is believed that the incident was not an accident and was done with intentions	F 225	procedures and how and who to immediately report to when an allegation of abuse occurs. Kenyon Sunset Home does use temporary pool staffing at times of need. We have updated our Nursing Floor Orientation for Pool Nursing Assistants and Nurses checklist to include the Kenyon Sunset Home specific Vulnerable Adult/Abuse Prevention Policy and procedure. Temporary pool staff are also informed of the location where the Administrator, Director of Nursing and Licensed Social Worker s contact information can be found. Kenyon Sunset Home s policy requires that all alleged violations involving resident mistreatment, neglect, and abuse, injuries of unknown source and misappropriation of property be: A) reported immediately to the Administrator, person in charge and appropriate state agencies, and B) thoroughly investigated within five days with the investigative results reported to the administrative staff and state agencies as required. If the alleged violation is verified, appropriate corrective action will be taken. The facility intervenes to prevent further potential abuse while the investigation is in process and ensures that residents are safe. 4) To ensure all employees understanding, knowledge and compliance with this policy, it will be reviewed and discussed at our mandated yearly in-services which are scheduled on a regularly basis for all employees.	

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F 225	Continued From page 7 of harming the resident the social worker/director of nursing must be contacted immediately as it has to be reported immediately."	F 225	5) Completion date: January 23, 2015	
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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their policy regarding allegations of neglect were immediately reported to the administrator and state agency for 1 of 5 residents (R9999) reviewed for abuse prohibition. Findings included: The facility policy entitled Vulnerable Adult/Abuse Prevention Policy last revised on November 7, 2013 read, "The law stipulates that all employees are mandated reporters of any suspected incidents of maltreatment/neglect. They are to report immediately if: one has knowledge of maltreatment/neglect of a resident, one has reasonable cause to believe that a resident has been maltreated ...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 immediately. " R9999 had an incidents and accidents report that revealed an allegation of neglect. A licensed practical nurse (LPN)-B made an allegation of neglect that occurred on the evening shift of	F 226	F226 Kenyon Sunset Home strives to ensure that each resident s allegation of abuse, neglect, mistreatment or misappropriation of their property is reported immediately to facility Administrator and person in charge according to the Vulnerable Adult/Abuse Prevention Policy and procedures the prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1) R9999 deceased on March 12, 2014. 2) All Kenyon Sunset Home residents residing in the facility have the potential to be affected by the same deficient practice, especially those who are unable to voice their own concerns. 3) Kenyon Sunset Home s Vulnerable Adult/Abuse Prevention Policy has been	1/23/15

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F 226	Continued From page 8 3/11/14, however failed to report the incident immediately to the administrator and to the state agency. Facility documentation indicated LPN-B reported to the licensed social worker (LSW)-A two days later on 3/13/14 at 2:30 p.m. LSW-A notified the administrator of the allegation on 3/13/14 3:00 p.m. and the director of nursing (DON) at 3:09 p.m. LSW-A filed the initial investigation to the Office of Health Facility Complaints (OHFC) on 3/13/14 at 3:15 p.m. During an interview on 12/18/14 at 2:30 p.m., LSW-A verified incident was not reported immediately to administrator or designated state agency.	F 226	updated. All Kenyon Sunset Home residents residing in the facility will be updated on Vulnerable Adult/Abuse Prevention Policy and procedures. Residents will also be updated on how to report and who to report to and types of abuse (example neglect, abuse, mistreatment, etc.).Kenyon Sunset Home staff has been re-educated on Vulnerable Adult/Abuse Prevention Policy, procedures and how and who to immediately report to when an allegation of abuse occurs. Kenyon Sunset Home does use temporary pool staffing at times of need. We have updated our Nursing Floor Orientation for Pool Nursing Assistants and Nurses checklist to include the Kenyon Sunset Home specific Vulnerable Adult/Abuse Prevention Policy and procedure. Temporary pool staff are also informed of the location where the Administrator, Director of Nursing and Licensed Social Worker s contact information can be found. Corrective action will occur if it is found that employees of Kenyon Sunset Home are not following this policy and procedure. 4) To ensure all employees understanding, knowledge and compliance with this policy, it will be reviewed and discussed at our mandated yearly in-services which are scheduled on a regularly basis for all employees. The Temporary pool staffing agency will be notified if it is found that the temporary pool staff is not following this policy and procedure.	

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F 226	Continued From page 9	F 226	5) Completion date: January 23, 2015	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to accurately identify pain during a comprehensive assessment for 1 of 3 residents	F 278	F278 Kenyon Sunset Home strives to ensure	1/23/15

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F 278 Continued From page 10

(R15) with ongoing pain that was present during assessment.
Findings included:
R15 was admitted to the facility on 4/12/12. Physician orders signed by nurse practitioner on 12/11/14 included the following diagnoses: dementia, anxiety, depressive disorder, osteoarthritis, and peripheral vascular disease.
R15's physician orders included: Tylenol 650 milligrams (mg) four times a day by mouth for pain with a start date of 9/27/12 and Tramadol 25 mg twice per day and one dose (25 mg) as needed for rib pain with a start date of 5/17/12.
R15's quarterly Minimum Data Set (MDS) signed on 6/17/14 revealed a BIMS score of 12 out of 15, which indicated moderate cognitive impairment. The BIMS showed R15 had short term memory impairment. The pain assessment interview was conducted with R15. In order for the pain assessment interview to be accurate the resident needs to be able to recall a time period of five days. To the question, "Have you had pain or hurting at any time during the last 5 days?" R15 responded "no."
R15's medication administration record was reviewed and revealed, R15 was administered as needed (PRN) Tramadol (pain medication) during the assessment reference dates of 6/5/14 at 12:16 a.m. and on 6/7/14 at 2:30 a.m. for pain symptoms.
Nursing note dated 6/5/2014 at 12:16 a.m. read, "Resident having increased anxiety/restlessness and stated she aches all over did give prn Ativan and Tramadol with much relief obtained."
Nursing note dated 6/7/2014 at 2:33 a.m. read, "Resident having some increased anxiety/restlessness and unable to sleep complaining of generalized pain did give her prn Ativan and Tramadol with much relief obtained."

F 278

assessments are completed accurately and reflect the resident s current status.

1) According to R15 s BIMs score of 7 (completed on November 3, 2014), a Comprehensive Pain Assessment for the Cognitively Impaired was completed on January 14, 2015. R15 scored 0, indicating no pain at the current time. R15 s care plan was updated with current resident pain status and with a revised pain management plan.

2) All Kenyon Sunset Home residents residing in the facility have the potential to be affected by the same deficient practice. A comprehensive assessment for pain will be completed to determine its nature and intensity. This assessment will be completed: upon resident admission, quarterly, with significant change, annual reviews and as needed. The Brief Interview of Mental Status (BIMS) score will be used to determine which assessment to complete with resident. A BIMS score of 0-12 indicates cognitive impairment and thus the Comprehensive Pain Assessment Form for the Cognitively Impaired will be utilized. A BIMS score of 12-15 indicates that the resident is cognitively intact and thus the Comprehensive Pain Assessment Form for the Cognitively Intact will be utilized.

3) Kenyon Sunset Home s Pain Assessment and Management Policy has been reviewed and updated. Staff has been re-educated on the revised policy. Kenyon Sunset Home has developed a

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F 278	Continued From page 11 A comprehensive dementia pain assessment or a comprehensive pain assessment and evaluation were not in the medical record nor provided when requested. R15's quarterly MDS signed on 11/12/14 revealed a BIMS score of 7 out of 15, which indicated severe cognitive impairment. The BIMS showed R15 had short term memory impairment. The resident was unable to recall one word without verbal cues and was not able to recall the other two words with verbal cues given by staff. The pain assessment interview was conducted with R15. To the question, "Have you had pain or hurting at any time during the last 5 days?" R15 responded "no." Again the accuracy of R15 ' s response was not validated by other staff interview nor checking the medication administration record that showed R15 had pain medication in during this assessment period. A comprehensive dementia pain assessment or a comprehensive pain assessment or evaluation was not in the medical record for this time period nor provided when requested. During an interview on 12/19/14 at 10:00 a.m., registered nurse (RN)-A confirmed there was no other pain assessments in the medical record other than the MDS. Facility policy Pain Assessment and Management last revised on 2/6/13 read, "It is the policy of Kenyon Senior Living that all residents have the right for appropriate pain assessment and pain management. All residents will be assessed for presence, absence or history of pain on admission, quarterly, with a significant change in status, and with acute changes in condition which places resident at high risk for pain or discomfort and review pain assessment quarterly and as needed."	F 278	new Pain Management Flowsheet which nursing staff will be responsible for completing and then documenting findings in the interdisciplinary notes as well as in the Medication Administration Record. 4) The Director of Nursing will review Pain Management Flowsheets, Comprehensive Pain Assessments, as well as the MDS pain interviews, according to the MDS schedule, weekly for a 6 month duration and as needed thereafter. 5) Completion date: January 23, 2015	

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F 279	Continued From page 12	F 279		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan when a decline in range of motion (ROM) was evident for 1 of 1 resident, R18, reviewed with a passive range of motion program (PROM). Findings include: R18's quarterly Minimum Data Set (MDS) dated 11/11/14, identified the resident had severe cognitive impairment, was totally dependent on staff for all activities of daily living (ADLs), and had no functional limitations to the upper or lower extremities.	F 279	F279 Kenyon Sunset Home strives to develop comprehensive care plans for each resident and review and revise as necessary to accurately portray resident s current status and needs. 1) All residents at Kenyon Sunset Home, including R18 s care plans, closet care plans and kardexes have been reviewed and revised for all areas, included range	1/23/15

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F 279	Continued From page 13	F 279		

R18 was observed sitting in a reclining wheelchair on 12/17/14, at 12:45 p.m. R18's left hand was clenched into a tight fist, and her head was tilted towards her right shoulder. On 12/17/14, at 1:15 p.m. nursing assistant (NA)-F and NA-E were observed transferring R18 from the wheelchair into the bed using a mechanical Hoyer lift. R18 did not straighten her bent knees, unclench her left fist, or straighten her arms during the transfer. NA-E stated R18 was becoming more difficult to perform cares on because she was becoming more stiff, and the last few months it took 2 NA's to get R18 dressed in the morning because of her increased stiffness. NA-F stated R18's left hand was always clenched in a fist, and it was difficult to cut her nails because she would not release the fist. NA-F and NA-E both stated R18 had no PROM program they were instructed to be doing with the resident, but they tried to stretch her extremities when assisting her with getting dressed in the mornings.

R18's most current Physical Therapy (PT) Progress and Discharge Summary dated 8/8/14, indicated the resident was discharged from PT on 8/8/14, and an exercise program for nursing was established, nursing was instructed in the ROM program, the ROM program was established to prevent further contracture, and the discharge instructions were identified as, "... include continued ROM program with nursing."

R18's most current Occupational Therapy (OT) Progress and Discharge Summary dated 8/21/14, indicated the resident was discharged from OT on 8/21/14, and was to have upper extremity ROM program daily with nursing, and required total assist with completing the program. The OT Progress note indicated nursing was educated on completing the ROM program for R18.

Review of Therapy Recommendations to Nursing

of motion. Kenyon Sunset Home s Director of Nursing and Therapy department have reviewed and discussed R18 s range of motion to prevent any decline in her range of motion abilities. The updated range of motion plans of care for all residents, including R18, have been provided to nursing staff to ensure the daily completion of range of motion exercises.

2) Residents at Kenyon Sunset Home who have contractures and could have declines in their range of motion ability have the potential of being affected by this deficient practice.

3) Kenyon Sunset Home s Range of Motion Policy has been revised. Nursing department staff has been reeducated on range of motion programs as well as proper exercises that should be done as recommended by the therapy department. Therapies will communicate range of motion program recommendations to nursing staff. To ensure the completion of range of motion programs, the program will be added to the identified residents daily treatment sheets, which the floor nurse is to verify completion and sign off on.

4) The facility Medical Records LPN will monitor the completion of the range of motion program on a monthly basis for a duration of 6 months and as needed thereafter.

5) Completion date: January 23, 2015.

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F 279	Continued From page 14 Staff form dated 8/11/14, instructed staff, "ROM program: Assist [R18] with exercises as listed on enclosed sheets. They may be done in bed or with chair in reclined position." Another document titled Flex and Extend the Shoulder with R18's name written on top which was dated 8/21/14, indicated, "Please perform daily from bed base; slow and gentle; Explain to [R18] what you are doing; perform each exercise 5-10 repetitions." Both of these forms were in a stapled packet which contained pictures and instructions of PROM exercises for both the upper and lower extremities staff was instructed to assist R18 to complete. R18's care plan dated 12/17/14 indicated the resident required staff assistance with ADLs. R18's care plan did not address R18's current PROM program recommendations as assessed by therapy. During interview on 12/17/14, at 2:10 p.m. NA-D stated R18 did not have a specific ROM program staff was instructed to complete. NA-D stated staff tried to stretch R18 when getting her dressed in the morning. During interview on 12/17/14, at 2:15 p.m. licensed practical nurse (LPN)-C stated R18 was not receiving any ROM program services. LPN-C was not aware of any current or past therapy orders for R18 to receive any ROM services. During interview on 12/17/14, at 1:55 p.m. Occupational Therapist (OT)-A stated she had assessed R18 back in August 2014, and when R18 was discharged from therapy, she had provided nursing instruction on assisting R18 with daily ROM, and also provided pictures of the ROM exercises to complete. OT-A stated she was not aware R18 had not been receiving any ROM, and would have expected nursing to complete the ROM program or refer the resident	F 279		

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F 279	Continued From page 15 back to therapy if there was a problem completing it. During interview on 12/17/14, at 3:10 p.m. the director of nursing (DON) stated if a resident had a ROM program ordered, it would be on the residents daily treatment sheets for nursing to sign off it was being completed. DON verified R18 had no ROM services on the daily treatment sheets, and was not aware if the resident was receiving any ROM. On 12/17/14, at 4:00 p.m. OT-A did gentle PROM to R18's extremities, and stated it did not appear R18's contractures had gotten any worse since the resident was discharged from therapy in August 2014, and the resident did not experience a decline due to not receiving any ROM services. The facility policy titled Range of Motion dated 10/1/13, indicated the purpose of resident ROM was to improve or maintain joint mobility and muscle strength, to prevent contractures, to reduce pain, and to prevent complications of mobility.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		1/23/15

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F 280	Continued From page 16 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 care plan regarding transfer assistance required for 1 of 3 residents (R10) reviewed for accidents. Finding Include: R10's significant change Minimum Data Set (MDS) dated 7/8/14, identified diagnoses of dementia, atrial fibrillation and diabetes mellitus. R10 had moderate cognitive impairment and required extensive assist from one staff for activities of daily living, which included mobility and transfers. The Care Area Assessment (CAA) dated 7/14/14 identified R10 had dementia, was at risk for injury d/t [due to] not remembering his abilities to perform without assistance. Further, the CAA identified R10 was at risk for falls and injury d/t [due to] falls, d/t [due to] history of falls, dementia and assistance required to transfer and ambulate. R10's plan of care last revised 8/23/14 read, " Falls: Resident is at high risk for falls r/t [related to] meds [medications] receiving, unsteady gait ... independence with 4WW [four wheeled walker], personal hx [history] of fall. " Last fall 2/5/14 no injuries. Interventions included but were not	F 280	F280 Kenyon Sunset Home strives to develop comprehensive care plans for each resident and review and revise as necessary to accurately portray resident s current status and needs. 1) R10 s care plan, closet care plan and kardex were revised regarding the transfer assistance that he is requiring as specified by the facility therapy department. 2) All residents at the facility have the potential to be affected by this deficient practice as all residents required transfer assistance needs may continually change. 3) The facility therapy department will evaluate all residents in the facility upon admission and as needed. Therapy will then provide the nursing department with the recommended assistance level for transfers to be used for the resident. The therapy recommendations will be used to revise the resident s care plan, closet	

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F 280	Continued From page 17 limited to, "staff to monitor resident every 2 hours and prn [as needed], Fall Risk Assessment quarterly and prn [as needed], stand by assist of one and walker for all transfers, alarm to wheelchair and recliner to alert staff if resident is attempting to self transfer." R10's resident Kardex read, "ADL'S [activities of daily living]: transfer with assist of one with walker; pad alarm in chair ..." R10's care plan that is kept in the resident's closet and referred to by staff as a " closet care plan " last revised 8/23/14 read, "ADL [activities of daily living] assistance: Transfer Staff Support: 1 assist. Walking/Ambulation: Staff Assist: 1 assist and gait belt. Equipment Needed: 4 wheeled walker. Fall Risk: Pressure alarm: Bed Alarm: yes. Chair Alarm: yes." R10's Therapy Recommendations to Nursing Staff dated 12/12/14 read, assist of two for all transfers with a gait belt and walker. However, this was not changed in the current care plan. During an interview on 12/18/14 3:41 p.m., the director of nursing verified on 12/12/12/14 therapy made the recommendation for R10 to have two assist for transfers and verified the plan of care had not been revised to reflect this change. On 12/19/14 at 10:31 a.m. physical therapist (PT)-A stated the current therapy recommendation was made on 12/12/14 for R10 to receive assist of two staff with transfers and stated R10's plan of care should have been revised to reflect this change. On 12/19/14 at 10:36 a.m. occupational therapist (OT)-A stated she expected the care plans to be updated to reflect the current therapy recommendation for two person assist for	F 280	care plan and kardex to ensure they are receiving the proper assistance required. 4) To ensure proper completion, the facility interdisciplinary team will review any recommendation changes made by the therapy department and cross check them with the current resident care plan, closet care plan and kardex. This will be completed weekly for duration of 6 months and as needed thereafter. 5) Completion date: January 23, 2015.	

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F 280	Continued From page 18 transfers once the recommendation from therapy was made. On 12/19/14 at 11:00 a.m. nursing assistant (NA)-C stated she transferred R10 with stand by assist of one and did not even need to hold on to the gait belt as R10 "can do it." NA-C stated there were a chart on the closet wall and a chart at the nurse ' s station with a resident Kardex where she can get information to know what cares to provide to residents. On 12/19/14 at 11:06 a.m. nursing assistant (NA)-B stated if R10 was alert and orientated, she would use a gait belt, walker and one person assist to transfer R10. NA-B stated she was made aware of transfer status of residents by the care plan kept in the resident's closet. On 12/19/14 at 11:15 a.m. nursing assistant (NA)-D stated R10 was an assist of one for transfers and had been since she started working at the facility. Review of the Resident Care Plan policy dated 2/7/13 included: "...The Resident Care Plan is reviewed and revised by the interdisciplinary team as determined by the Resident's needs ..."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		1/23/15

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F 282 — Continued From page 19

by:
Based on observation, interview and document review, the facility failed to ensure the written care plan was followed for monitoring of skin concerns, related to identifying and reporting bruises for 1 of 3 residents (R10) reviewed for non-pressure related skin conditions.

Findings include:

R10 was observed on 12/16/14 at 2:55 p.m. to have a bruise on his right and left forearms and right first finger with no documentation of these bruises being assessed for cause or ruled out for possible abuse until the staff had been informed by surveyor on 12/19/14 of their existence.

R10's significant change in status Minimum Data Set (MDS) assessment dated 7/8/14, identified diagnoses including: dementia, atrial fibrillation and diabetes mellitus. This MDS also indicated R10 had moderate cognitive impairment and required extensive assist from one staff for activities of daily living, which included mobility and transfers.

R10's plan of care last revised 8/23/14 included: "Daily skin checks with cares, report to nurse any abnormal findings, Weekly skin check and nail care by licensed nurse."

On 12/19/14 at 12:52 p.m., an observation was completed by the director of nursing (DON) and surveyor. The DON assessed R10's arms and hands for any alteration in skin integrity. The DON assessed R10 to have the following bruises: left inner arm near the wrist, measured two inches in width and 1 inch in length appearing purple and yellow in color, a bruise on left pointer finger that

F 282 — Provider's plan of correction:

F282

Kenyon Sunset Home strives to ensure that the services that are provided or arranged by the facility are always provided by qualified persons in accordance with each resident s written plan of care.

1) Resident R10 s care plan has been reviewed and revised with special attention on skin risk related to bruises. The affected resident s treatment sheets have also been updated with monitoring of bruises by nursing until healed. Staff have been re-educated on reporting bruises immediately to the floor nurse per Bruise Monitoring Policy.

2) All residents that reside at Kenyon Sunset Home have the potential to be affected by this deficient practice due to fragile skin and the potential for bruising.

3) Bruise Monitoring Policy has been reviewed and updated. Staff have been re-educated on the procedure of reporting, documenting, investigating and monitoring bruises on residents. Skin checks will continue to be completed weekly on bath day by licensed nurse. All incidents that involve bruises will be reviewed and investigated by the interdisciplinary team to determine root cause of bruising as well as interventions to prevent any future bruising.

4) Upon discovery or report of bruising

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F 282	Continued From page 20 measured 0.5 cm (centimeters) in length and 1 cm in width that was purple in color, a bruise on right mid arm near wrist that measured 1 cm in width and 1.5 cm in length, which was pink and purple in color, a bruise on right mid arm that measured 1.5 inches in width and 1 inch in length, and appeared pink and purple in color, a bruise on right pointer finger that measured 0.5 inch in width and 1 inch in length, also purple in color. The DON verified there had been no incident reports made regarding the identified bruises and stated an incident report should have been made. The DON verified none of the staff that provided direct resident care for R10 since 12/16/14 at 2:55 p.m. had reported the bruises per facility policy. The DON verified R10's plan of care was not followed for monitoring skin. A policy was requested for following a care plan and none was provided.	F 282	staff nurse will document size, color, pattern on incident report and document in interdisciplinary notes. Staff nurse will also interview resident regarding possible cause of bruise(s). Staff nurse will also initiate monitoring of bruising in treatment book until healed. The interdisciplinary team will review treatment book weekly for a duration of six months and as needed thereafter to ensure that all bruises have been identified and Bruise Monitoring Policy is being followed. 5) Completion date: January 23, 2015	
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 identify bruises for 1 of 3 residents (R10) reviewed for non-pressure related skin conditions; failed to assess ongoing effectiveness of pain medication for 1 of 5	F 309	F309 Kenyon Sunset Home strives to ensure each resident receives and the facility provides the necessary care and services	1/23/15

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F 309	Continued From page 21 residents (R15) reviewed in the sample for unnecessary medications; and failed to use dementia training interventions for 1 of 1 residents (R10) in the sample who refused eye ointment. Findings Include: R10 was observed on 12/16/14 at 2:55 p.m. to have a bruise on his right and left forearms and right first finger with no documentation of these being found until the staff were informed of them by surveyor on 12/19/14. R10's significant change in status Minimum Data Set (MDS) dated 7-8-14, identified diagnoses of dementia, atrial fibrillation and diabetes mellitus. R10 had moderate cognitive impairment and required extensive assist from one staff for activities of daily living, which included mobility and transfers. The Care Area Assessment (CAA) dated 7-14-14 identified R10 had dementia, was at risk for injury d/t [due to] not remembering his abilities to perform without assistance. Further, The CAA identified R10 was a risk for falls and injury d/t [due to] falls d/t [due to] history of falls, dementia and assistance required to transfer and ambulate. R10's plan of care last revised 8/23/14 read, Daily skin checks with cares, report to nurse any abnormal findings, Weekly skin check and nail care by licensed nurse." R10's December 2014 progress notes were reviewed and there was no documentation in regards to the bruises on his right and left forearms and right first finger. On 12/17/14 at 2:55 p.m. nursing assistant	F 309	to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1) a. Resident R10 s care plan has been reviewed and revised with special attention on skin risk related to bruises. The affected resident s treatment sheets have also been updated with monitoring of bruises by nursing until healed. Staff have been re-educated on reporting bruises immediately to the floor nurse per Bruise Monitoring Policy. b. According to R15 s Brief Interview of Mental Status (BIMS) score of 7 (completed on November 3, 2014), a Comprehensive Pain Assessment for the Cognitively Impaired was completed on January 14, 2015. R15 scored 0, indicating no pain at the current time. R15 s Care Plan was updated with current resident pain status and with a revised pain management plan. c. The LPN who did not utilize dementia training to address resident R10 s refusal of taking medications has received one to one reeducation from the facility Director of Nursing. The Director of Nursing has reeducated all licensed nursing staff on utilizing dementia training to address resident s refusal rights. 2) a. All residents that reside at Kenyon Sunset Home have the potential to be affected by this deficient practice due to	

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F 309	Continued From page 22 (NA)-D stated she monitored resident skin for bruising when providing cares daily and reported any bruises to the nurse right away. On 12/19/14 at 12:49 a.m. the director of nursing (DON) stated she expected all staff to report on bruises. The DON stated she expected the aides to report all bruises to the floor nurse immediately when they discovered the bruise. The DON stated she expected the nurse to complete an incident report, make an assessment of the bruises and add the bruises to the treatment sheets for monitoring. R10 was observed on 12/19/14 at 12:52 p.m. by the DON and surveyor. The DON assessed R10's arms and hands for any alteration in skin integrity. The DON assessed R10 to have the following bruises: left inner arm near the wrist, measured two inches in width and 1 inch in length that was purple and yellow in color, bruise on left pointer finger that measured 0.5 cm (centimeters) in length and 1 cm in width that was purple in color, bruise on right mid arm near wrist that measured 1 cm in width and 1.5 cm in length, pink and purple in color, bruise on right mid arm that measured 1.5 inches in width and 1 inch in length, pink and purple in color, bruise on right pointer finger that measured 0.5 inch in width and 1 inch in length, purple in color. The DON verified there had been no incident reports made regarding the identified bruises and stated an incident report should have been made. The DON verified none of the staff that provided direct resident care for R10 since 12/16/14 at 2:55 p.m. had reported the bruises per facility policy. The DON verified R10's plan of care was not followed for monitoring skin.	F 309	fragile skin and the potential for bruising. b. All residents that reside at Kenyon Sunset Home have the potential to be affected by the same deficient practice. A comprehensive assessment for pain will be completed to determine its nature and intensity. This assessment will be completed: upon resident admission, quarterly with significant change, annual reviews and as needed. The BIMS score will be used to determine which assessment to complete with resident. A BIMS score of 0-12 indicates cognitive impairment and thus the Comprehensive Pain Assessment Form for the Cognitively Impaired will be utilized. A BIMS score of 12-15 indicates that the resident is cognitively intact and thus the Comprehensive Pain Assessment Form for the Cognitively Intact will be utilized. c. All residents that reside at Kenyon Sunset Home who have diagnosed dementia or have cognitive impairment have the potential to be affect by this deficient practices. 3) a. Bruise Monitoring Policy has been reviewed and updated. Staff have been re-educated on the procedure of reporting, documenting, investigating and monitoring bruises on residents. Skin checks will continue to be completed weekly on bath day by licensed nurse. All incidents that involve bruises will be reviewed and investigated by the interdisciplinary team to determine root cause of bruising as well as interventions to prevent any future bruising.	

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F 309 Continued From page 23

The Bruise Monitoring policy dated 10-23-13 read, "It is the policy of Kenyon Senior Living to report and monitor bruises that are present on all residents. Procedure: a. nursing assistants will report any bruises to floor nurse upon discovery. b. Nurse will gather data related to bruise (measurement, color, pattern) and document in interdisciplinary notes. c. Nurse will initiate monitoring of bruise size and color in treatment book until healed. d. Incident report to be completed and reviewed by IDT [interdisciplinary team]."

LACK OF PAIN REASSESSMENT WITH CHRONIC USE OF AS NEEDED PAIN MEDICATION:

R15 was admitted to the facility on 4/12/12. Physician orders signed by nurse practitioner on 12/11/14 included the following diagnoses: dementia, anxiety, depressive disorder, and peripheral vascular disease.

R15's quarterly MDS signed on 6/17/14 revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated moderate cognitive impairment and the pain assessment indicated the resident had not experienced pain.

R15's quarterly MDS signed on 11/12/14 revealed a BIMS score of 7 out of 15, which indicated severe cognitive impairment and the pain assessment indicated the resident had not experienced pain.

R15's care plan last reviewed by the facility on 6/17/14 read, "Pain management: resident denies pain this quarter. Has the potential for increase in pain related to history of fall with fractures ...." R15's goal read, "Resident will have little or no pain through the next review date." Interventions included, " give pain medications as ordered, PT/OT [physical therapy and occupation therapy]

F 309

b. Kenyon Sunset Home s Pain Assessment and Management Policy has been reviewed and updated. Pain assessments will be completed upon admission, quarterly, with significant change and annually by nurse manager.

c. To ensure that this practice will not reoccur a Resident Refusal Rights Policy has been created which states, The facility will respect the right of the resident, as well as their choices related to accepting or refusing medications, treatments and recommendations given by certified professionals. It explains that when a resident refuses treatment, medication or restriction they shall be informed of the likely medical or major psychological results of the refusal. If the resident continues to wish to refuse after given this information staff will respect these wishes and reattempt to administer the medication or treatment after approximately 20 minutes. If resident still declines the administering of the mediation or treatment at this time staff will document this in the resident s medical record and medication administration records.

4)

a. Upon discovery or report of bruising staff nurse will document size, color, pattern on incident report and document in interdisciplinary notes. Staff nurse will also interview resident regarding possible cause of bruise(s). Staff nurse will also initiate monitoring of bruising in treatment book until healed. The interdisciplinary team will review treatment book weekly

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F 309	Continued From page 24 as ordered, Notify MD [medical doctor] if significant change or increase of pain occurs, encourage activity/mobility with one assist, pain assessment quarterly/prn." Care plan also included: resident has moderate cognitive impairment, intermittent confusion, and makes poor safety judgments. R15's physician orders included: Tylenol 650 milligrams (mg) four times a day by mouth for pain with a start date of 9/27/12 and Tramadol 25 mg twice per day and one dose (25 mg) as needed for rib pain with a start date of 5/17/2012 and Ativan 0.5 mg by mouth every 6 hours as needed for anxiety. R15's medication administration record (MAR) for June 2014 was reviewed; findings included R15 administered one dose of as needed Tramadol on sixteen different nights between the hours of 12:30 a.m. and 4:40 a.m., on fifteen of those occasions Ativan was administered at the same time for anxiety and restlessness. Nursing documentation indicated reason for as needed dose of Tramadol was "generalized" pain. Documentation lacked characteristics of generalized pain and non-pharmacological measures for pain relief. Nursing documentation did not indicate prior to the administration of Tramadol and Ativan together nursing had evaluated or assessed the resident to determine if resident was experiencing pain or anxiety or if non-pharmacological interventions were attempted and effective. R15's MAR for July 2014 was reviewed, findings included R15 was administered one dose of as needed Tramadol on twenty different nights between the hours of 11:00 p.m. and 5:30 a.m. for generalized pain. Ativan for anxiety was administered with every Tramadol dose. Documentation lacked characteristics of	F 309	for duration of six months and as needed thereafter to ensure that all bruises have been identified and Bruise Monitoring Policy is being followed. b. The Director of Nursing will review Pain Management Flowsheets, Comprehensive Pain Assessments, as well as the MDS pain interviews, according to the MDS schedule, weekly for a 6 month duration and as needed thereafter. c. Monitoring the compliance of honoring the resident s right to refuse will be completed weekly. This will be done by an audit of the resident s medical and treatment administration records, interdisciplinary notes as well as random resident interviews. These audit measures will be completed by the interdisciplinary team. 5) Completion date: January 23, 2015.	

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F 309	Continued From page 25 generalized pain and non-pharmacological measures for pain relief. Nursing documentation did not indicate prior to the administration of Ativan and Tramadol together nursing had evaluated or assessed the resident to determine if resident was experiencing pain or anxiety. R15's MAR for December 1 -18, 2014 was reviewed, findings included R15 was administered one dose of as needed tramadol on 5 different nights between 11:30 p.m. and 4:00 a.m. for generalized pain. Ativan for anxiety was given with the Tramadol on three occasions. Documentation lacked characteristics of generalized pain and non-pharmacological measures for pain relief. Nursing documentation did not indicate prior to the administration of Ativan and Tramadol together nursing had evaluated or assessed the resident to determine if resident was experiencing pain or anxiety. R15's medical record lacked an ongoing comprehensive pain assessments and/or evaluations from the time period reviewed from January to December 2014 and none was provided when requested. During an interview on 12/18/14 at 10:00 a.m., nurse practitioner (NP)-A stated Tramadol and Ativan could be taken together to make R15 comfortable. NP-A indicated determining if R15 had pain that contributed to anxiety would be too complicated to determine because of her diagnosis of dementia. Facility policy Pain Assessment and Management last revised on 2/6/13 read, "if the resident displays behaviors which could possibly indicate pain or discomfort, consult with physician or nurse practitioner regarding a trial pain management program, implement charting and reassess to see if there is improvement with behaviors., Notify MD/NP of pain assessment	F 309		

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F 309	Continued From page 26 findings if pain is indicated to start or change pain management program as necessary with ongoing evaluation of effectiveness of medications prescribed., Initiate and/or update care plan to include type of pain, required monitoring including pain management plan and a measurable goal relating to the pain management plan., and review pain assessment quarterly and as needed. Note any changes or revisions in current plan." FAILURE TO USE DEMENTIA TRAINING TO ADDRESS REFUSAL OF TAKING MEDICATIONS: R10 was admitted to the facility on 9/15/11. Diagnoses from signed physician visit from 11/6/14: Dementia, depression, edema, anemia, history of kidney failure, diabetes, difficulty in walking, peripheral vascular disease. R10's Minimum Data Set (MDS) dated 7/8/14 revealed a BIMS score of 7 out a possible 15 which indicated severe cognitive impairment. The MDS indicated resident experienced delusions and had 1-3 episodes R10 ' s MDS dated 11/25/14 indicated R10 was not able to complete the BIMS assessment. Nursing staff had determined and indicated on the MDS R15 was rarely or never understood. A nursing note dated 12/16/14 read, " Resident yelled out and pulled away from the nurse applying eye gtts [drops]. " " YOU DON'T KNOW WHAT YOU ARE DOING, YOU ARE HURTING ME! " When asked to tip head back and open eyes, R10 closed them even tighter and yelled more " YOU DON'T KNOW A [curse word] THING THAT [curse word] DOESN'T DO ANY GOOD. " Nurse explained that if the medicine wasn't applied to R10 ' s eyes they would be worse. R10 said, "OH [curse word], YOU NEED THE FLYING MARE .....!" It was learned that the medication nurse failed to use dementia training	F 309		

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F 309	Continued From page 27 techniques to avoid escalation of behavior by reproaching at a later time. R10 ' s care plan last reviewed 8/23/14 read, " Behavioral symptoms: no behaviors were noted during this review period. " The care plan lacked risk for developing dementia related behavioral symptoms with individualized interventions or addressed risk for behaviors based on history of behaviors. R10 ' s December 2014 daily behavior monitoring indicated the target behaviors of negative statements, resistive to cares, isolating to room and hallucinations. Interventions included 1:1 visits, encourage activities outside of room, offer snack, and offer choices and re-approach. However, there was no intervention to address frequent refusal of medications and treatments. During an interview on 12/19/14 at 11:44 a.m., licensed practical nurse (LPN)-A explained if the medication had not been administered to R10 the nurse would put a circle around the their initials and write a note on the back of the medication administration record. LPN-A stated R10 had not refused eye ointment in the past. During an interview on 12/19/14 at 11:05 a.m., licensed social worker (LSW)-A stated the insistence to give eye ointment after the resident refused and was getting more upset with persistence of nurse to give the medication was not acceptable. LSW-A confirmed intervention of re-approaching the resident at a later time should have been used.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives	F 318		1/23/15

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F 318	Continued From page 28 appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident, (R18), reviewed with a passive range of motion program (PROM) was being completed as assessed to ensure the resident did not develop further contractures. Findings include: R18's quarterly Minimum Data Set (MDS) dated 11/11/14, identified the resident had severe cognitive impairment, was totally dependent on staff for all activities of daily living (ADLs), and had no functional limitations to the upper or lower extremities. R18 was observed sitting in a reclining wheelchair on 12/17/14, at 12:45 p.m. R18's left hand was clenched into a tight fist, and her head was tilted towards her right shoulder. On 12/17/14, at 1:15 p.m. nursing assistant (NA)-F and NA-E were observed transferring R18 from the wheelchair into the bed using a mechanical Hoyer lift. R18 did not straighten her bent knees, unclench her left fist, or straighten her arms during the transfer. NA-E stated R18 was becoming more difficult to perform cares on because she was becoming more stiff, and the last few months it took 2 NA's to get R18 dressed in the morning because of her increased stiffness. NA-F stated R18's left hand was always clenched in a fist, and it was difficult to cut her nails because she would not release the fist. NA-F and NA-E both stated R18 had no PROM program they were instructed to be doing	F 318	F318 Kenyon Sunset Home strives to ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. 1) All residents at Kenyon Sunset Home, including R18 s care plans, closet care plans and kardexes have been reviewed and revised for all areas, included range of motion. Kenyon Sunset Home s Director of Nursing and Therapy department have reviewed and discussed R18 s range of motion to prevent any decline in her range of motion abilities. The updated range of motion plans of care for all residents, including R18, have been provided to nursing staff to ensure the daily completion of range of motion exercises. 2) Residents at Kenyon Sunset Home who have contractures and could have declines in their range of motion ability have the potential of being affected by this deficient practice. 3) Kenyon Sunset Home s Range of	

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F 318	Continued From page 29 with the resident, but they tried to stretch her extremities when assisting her with getting dressed in the mornings. R18's most current Physical Therapy (PT) Progress and Discharge Summary dated 8/8/14, indicated the resident was discharged from PT on 8/8/14, and an exercise program for nursing was established, nursing was instructed in the ROM program, the ROM program was established to prevent further contracture, and the discharge instructions were identified as, "... include continued ROM program with nursing." R18's most current Occupational Therapy (OT) Progress and Discharge Summary dated 8/21/14, indicated the resident was discharged from OT on 8/21/14, and was to have upper extremity ROM program daily with nursing, and required total assist with completing the program. The OT Progress note indicated nursing was educated on completing the ROM program for R18. Review of Therapy Recommendations to Nursing Staff form dated 8/11/14, instructed staff, "ROM program: Assist [R18] with exercises as listed on enclosed sheets. They may be done in bed or with chair in reclined position." Another document titled Flex and Extend the Shoulder with R18's name written on top which was dated 8/21/14, indicated, "Please perform daily from bed base; slow and gentle; Explain to [R18] what you are doing; perform each exercise 5-10 repetitions." Both of these forms were in a stapled packet which contained pictures and instructions of PROM exercises for both the upper and lower extremities staff was instructed to assist R18 to complete. R18's care plan dated 12/17/14 indicated the resident required staff assistance with ADLs. R18's care plan did not address R18's current PROM program recommendations as assessed	F 318	Motion Policy has been revised. Nursing department staff has been reeducated on range of motion programs as well as proper exercises that should be done as recommended by the therapy department. Therapies will communication range of motion program recommendations to nursing staff. To ensure the completion of range of motion programs, they will be added to the identified residents daily treatment sheets, which the floor nurse is to verify completion and sign off on. 4) The facility Medical Records LPN will monitor the completion of the range of motion program on a monthly basis for duration of 6 months and as needed thereafter. 5) Completion date January 23, 2015.	

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F 318	Continued From page 30	F 318		

by therapy.
During interview on 12/17/14, at 2:10 p.m. NA-D stated R18 did not have a specific PROM program staff was instructed to complete. NA-D stated staff tried to stretch R18 when getting her dressed in the morning.
During interview on 12/17/14, at 2:15 p.m. licensed practical nurse (LPN)-C stated R18 was not receiving any ROM program services. LPN-C was not aware of any current or past therapy orders for R18 to receive any ROM services.
During interview on 12/17/14, at 1:55 p.m. Occupational Therapist (OT)-A stated she had assessed R18 back in August 2014, and when R18 was discharged from therapy, she had provided nursing instruction on assisting R18 with daily PROM, and also provided pictures of the PROM exercises to complete. OT-A stated she was not aware R18 had not been receiving any PROM, and would have expected nursing to complete the PROM program or refer the resident back to therapy if there was a problem completing it.
During interview on 12/17/14, at 3:10 p.m. the director of nursing (DON) stated if a resident had a PROM program ordered, it would be on the residents daily treatment sheets for nursing to sign off it was being completed. DON verified R18 had no PROM services on the daily treatment sheets, and was not aware if the resident was receiving any PROM.
On 12/17/14, at 4:00 p.m. OT-A did gentle PROM to R18's extremities, and stated it did not appear R18's contractures had gotten any worse since the resident was discharged from therapy in August 2014, and the resident did not experience a decline due to not receiving any PROM services.
The facility policy titled Range of Motion dated

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F 318	Continued From page 31 10/1/13, indicated the purpose of resident PROM was to improve or maintain joint mobility and muscle strength, to prevent contractures, to reduce pain, and to prevent complications of mobility.	F 318		
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 implement interventions and comprehensively assess risk factors for falls, in order to prevent falls for 1 of 3 residents (R10) reviewed with a history of falls. In addition, the facility failed to ensure toxic chemicals were securely stored on 1 of 2 units. Findings include: Failure to implement interventions and/or assess for falls: R10's significant change Minimum Data Set (MDS) dated 7/8/14, identified R10 had moderate cognitive impairment, required extensive assist from staff for activities of daily living including mobility and transfers. R10 ' s Care Area Assessment (CAA) dated 7/14/14, identified R10	F 323	F323 Kenyon Sunset Home strives to ensure that all resident environments remain as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1) a. An updated fall risk assessment for resident R10 has been completed. Resident R10 s room has also been rearranged to allow more open floor space and help prevent future falls. He continues to work with occupational and physical therapy to improve his gait and stability to help prevent future falls. b. All chemicals stored within the facility	1/23/15

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had dementia, was at risk for injury due to not remembering his abilities to perform daily activities without staff assistance, and was at risk for falls and injury due to a history of falls, dementia, and requiring staff assistance to transfer and ambulate.

R10's care plan dated 8/23/14, indicated the resident was at high risk for falls, and included interventions to monitor the resident every 2 hours and as needed, provide stand by assist of staff and walker for all transfers, and to ensure an alarm was placed on the wheelchair and recliner to alert staff if the resident was attempting to self-transfer.

R10's Closet Care Plan (a working care plan kept in the resident's closet to alert nursing assistants how to care for a resident) also dated 8/23/14, indicated R10 required transfer and walking assistance of one staff with a wheeled walker, and was to have both bed and chair alarms applied.

R10 was observed on 12/18/14, at 4:00 p.m. sitting in his recliner. During the observation R10 ' s wheelchair was next to the recliner and had a pressure alarm attached; however, the recliner the resident was sitting in did not have an alarm in place.

On 12/18/14, at 4:03 p.m. nursing assistant (NA)-E stated R10 should have a pressure alarm when sitting in either the recliner or wheelchair. NA-E verified R10 did not have the alarm in place in the recliner while he sat there. NA-E was observed to respond immediately by placing the pressure alarm in R10's recliner.

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have been secured behind locked doors to ensure toxic chemicals are securely stored so that no residents, especially those with cognitive impairments, are able to access them.

2)
a. All residents that are deemed to be a high fall risks have the potential of being affected by this deficient practice.
b. All residents, especially those known to have cognitive impairments, have the potential of being affected by this deficient practice.

3)
a. Upon admission and as needed, the facility RN will complete a fall risk assessment on the resident. If a resident is found to be at high risk for falls this will be communicated to all facility staff and fall safety measures will be put in place as seen appropriate for the specific resident. The resident s care plan, closet care plan and kardex will also up created and updated to reflect the high fall risk as well as the specific safety measures that have been put in place. When a resident is identified as a high fall risk the facility therapy department will also be notified, as well as when a fall occurs. When a fall occurs the licensed nurse is responsible to fill out the resident fall report form, related documentation as well as notify the family, physician, DON, LNHA and LSW. At the time of the fall the licensed nurse will implement immediate necessary interventions and treat per facility protocol, as well as follow the

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R10 was observed on 12/19/14, at 11:12 a.m. sitting in his recliner. During there observation, there was again no pressure alarm in place in the recliner. Licensed practical nurse (LPN)-A verified the pressure alarm was attached to R10's wheelchair, and should have been placed in the recliner when the resident had been assisted to the recliner.

A Resident Incident Report for R10 dated 12/8/14, indicated, " Resident observed to be laying on his right side on the floor. Head next to brake on bed and feet towards door to his room. Walker lying on its side by resident knees and dresser; with television on. " The Incident Report indicated R10 was sent to the emergency room with a 3 inch laceration on the back of his head, and R10 stated, "I was walking backward trying to get to my bed." The incident report did not include a comprehensive assessment of the fall including an assessment of whether the alarms had been in place and/or sounding, when the resident had last been toileted, whether the current fall interventions were adequate, or whether any new interventions should have been implemented. The incident report IDT (interdisciplinary team) comments included: "Therapy has changed resident to a two person transfer for now. He is currently on OT [occupational therapy]/ PT [physical therapy] three times a week. Will continue to monitor sutures to laceration on head."

R10's Nursing Progress note dated 12/9/14 regarding the fall from 12/8/14, included: "...Resident observed to be laying on the floor on his right side. Head by the brake pedal of his bed and feet towards his door to his room. Walker was on its side by resident's knees and the

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facility Falls-Procedure, Documentation, Assessment and Review Policy. The interdisciplinary team then reviews and investigates all resident falls. This will be completed by utilizing the interdisciplinary Post Fall Assessment. During this review the interdisciplinary team will analyze the resident s fall history, as well as any contributing factors to determine root cause. Changes to the resident s care plan, closet care plan, kardex and environment will be completed as determined by the interdisciplinary team s post fall assessment and investigation.
b. The facility has installed keyed locks on the doors of all chemical storage units within the resident environment.

4)
a. To ensure proper completion of fall risk assessments and documentation the facility interdisciplinary team will review these as well as any recommendation to prevent falls made by the therapy department. The interdisciplinary team will then ensure that the assessments and documentation and interdisciplinary post fall review correlate with their current resident care plan, closet care plan and kardex. This will be completely weekly for duration of 6 months and as needed thereafter.
b. To ensure that chemicals are securely stored at all times the facility housekeeping staff will monitor on a daily basis for a duration of 6 months and as needed thereafter.

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dresser with the TV [television] on it. 8 cm [centimeter] laceration to the back of his head on the right side. 4 X 4's and pressure applied. Resident stated he had closed his door tight and was walking backward to his bed when he fell. 911 called and resident was transported to the Faribault ER [emergency room] ..."

On 12/18/14 at 4:11 p.m. the licensed social worker (LSW)-A verified the incident report failed to indicate whether alarms were in place at the time of the fall on 12/8/14. LSW-A stated when the IDT reviewed incident reports for falls, they should identify incomplete sections of the incident reports during their review. LSW-A verified the facility had not conducted a root cause analysis of R10's fall from 12/8/14.

During interview on 12/19/14, at 10:10 a.m. the director of nursing (DON) stated there had been no further investigation of R10 ' s fall from 12/8/14, and that there had been no further investigation completed to determine whether R10's care plan had been followed. The DON said she had believed staff would have followed the care plan because they were aware of the resident's plan of care. However, the DON acknowledged there should have been additional follow-up related to R10's falls and this had not been completed.

On 12/19/14 at 10:31 a.m. physical therapist (PT)-A stated therapy had made a recommendation on 12/12/14, for R10 to have assist of two staff with transfers.

On 12/19/14 at 11:00 a.m. NA-C stated she transferred R10 with stand by assist of one and did not even need to hold on to the gait belt as

Provider's plan of correction (F 323):

5) Completion date January 23, 2015.

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R10, "can do it." NA-C stated there was a chart on the closet wall and a chart at the nurses station with a resident Kardex where she can get information to know what cares to provide to residents including R10.

On 11:06 a.m. at 12/19/14, NA-B stated if R10 was alert and orientated, she would use a gait belt, walker and one person assist to transfer R10. NA-B stated she was made aware of transfer status of residents by the care plan kept in the resident's closet.

On 12/19/14, at 11:15 a.m. NA-D was interviewed and stated R10 was an assist of one for transfers and had been since she ' d started working at the facility. NA-D also stated R10 had no current alarms in place for fall prevention. At 11:40 a.m. NA-D reapproached the surveyor and stated she was mistaken, and R10 did have a pressure alarm that was to be used in the wheelchair and recliner.

Review of the facility's Incident and Accident Reporting and Review policy, dated 12/7/14 indicated: "a. It is the policy of Kenyon Sunset Home to accurately chart resident's accidents and incidents on the Resident Incident Form. b. It is the policy of Kenyon Sunset home to have the Interdisciplinary Team review all accidents and incidents. Procedure: a. Resident incident Form is to be completed and turned into the DON. b. Interdisciplinary team reviews forms weekly. Interventions are put into place. A recap of previous week's incidents are reviewed. C. Monthly the Interdisciplinary Team reviews the month's Incident Forms to monitor for patterns."

Lack of securing caustic chemicals:

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F 323	Continued From page 36 During the initial tour on 12/15/14 at 7:28 a.m. licensed practical nurse (LPN)-A verified the bathroom/ tub room door was wedged open and the storage cabinet that contained hazardous chemicals had no lock. LPN-A verified the hazardous chemicals should have been locked up and stated the bathroom door should have been closed. LPN-A verified unlocked chemicals was a safety concern for cognitively impaired residents who could access the chemicals. LPN-A verified the following hazardous chemicals were stored in the unlocked cabinet: 2 spray bottles of 256 disinfectant, 1 three quart bottle of pure bright germicidal ultra-bleach cleaner, 1 spray bottle with fifteen ounces of bleach water, 1 three liter bottle of cen-klens IV cleaner one step disinfectant, and 1 thirty-two ounce bottle of cetylcide broad spectrum disinfectant. LPN-A also verified that there was a confused resident who ambulates in the area and could have access to the chemicals. On 12/19/14 at 2:31 p.m. the administrator verified the chemicals should be secured and locked up for resident safety.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		1/23/15

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F 329	Continued From page 37 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 attempt a dose reduction of a psychoactive medication after one year or a physician's justification as to why a reduction is contraindicated for 1 of 5 residents (R15) reviewed for unnecessary medication use. Findings included: Lack of an attempt to reduce medication after one year or a physician's justification as to why a reduction was contraindicated at this time: R15's physician orders signed and dated 12/11/14 directed Ativan 0.5 mg by mouth every six hours as needed for anxiety. The original start date of this medication was 6/27/13. R15's medication administration record (MAR) indicated Ativan was administered on 14 different occasions between 12/1/14 and 12/15/14. Nursing notes lacked documentation and assessment of non-pharmacological interventions	F 329	F329 Kenyon Sunset Home strives to ensure that each resident s drug regimen is free from unnecessary drugs. 1) Resident R15 s physicians orders were reviewed on 12/23/2014, by Medical Doctor. 2) All residents that reside at Kenyon Sunset Home have the potential to be affected by this deficient practice. 3) Kenyon Sunset Home s Medication Review and Reduction Policy as well as Gradual Dose Reduction Policy has been revised. Policy has been reviewed with our QAA team as well as our Medical Doctors, our Nurse Practitioner and	

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F 329	Continued From page 38 were attempted prior to the administration of Ativan. R15's medical record did not include a pharmacy recommendation or a physician's order to attempt a gradual dose reduction of Ativan since the start date of 6/27/13 nor was one provided when requested. During an interview on 12/18/14, at 7:18 p.m., Nurse practitioner (NP)-A stated she started with the facility in February of 2014. NP-A verified the original Ativan start date of 6/27/2013. NP-A said she had not recommended a dose reduction since she had started with the facility in February 2014 and that it had been an oversight. During an interview on 12/18/14, at 10:00 a.m., NP-A stated the expectation would be for nursing to document behaviors and attempt non-pharmacological interventions for anxiety/agitation. Facility policy Medication Review Reduction Policy dated 2/25/13 reads, "It is the policy of Kenyon Sunset Home to review resident's medications and reduce the medication to the lowest therapeutic dose possible, and Consultant pharmacist will review all resident's medications monthly for any unnecessary medications or contraindicated dosages."	F 329	nursing department staff. Resident s medication regimens are reviewed during Medical Doctor or Nurse Practitioner rounds, during our monthly pharmacy consultations as well as at the time of reviews according to the resident s MDS schedule. Gradual does reductions will be attempted per physicians orders. Recommendations will be given to the physician by the consulting pharmacist. Facility, resident and or responsible party concerns related to dosage will also be communicated to the physician. If the medical doctor determines that further gradual dose reductions are contraindicated they will provide proper detailed and resident specific documentation on the resident s inability to tolerate any further gradual does reductions in the residents medical record. 4) All gradual dose reductions will be tracked in the resident s chart, to monitor that the physician has proper knowledge of past attempts and outcomes of GDR to assure they are done in a timely manner. The consulting pharmacist will monitor to ensure GDRs are completed within the required time frames. 5) Completion date January 23, 2015	
F 441 SS=E	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	F 441		1/23/15

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F 441	Continued From page 39 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 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 use infection control practices to prevent the spread of infection while	F 441	F441 Kenyon Sunset Home strives to maintain	

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giving personal cares for 1 of 1 resident (R28) who was incontinent of bowel and bladder; failed to include all respiratory illnesses as part of the infection control process to prevent the spread of colds for 3 of 3 residents (R16, R18, R33) who had respiratory symptoms; and failed to monitor the effectiveness of antibiotics for 4 of 4 residents (R17, R19, R9997, R9998). This had the potential to affect all 23 residents in the facility.

Findings included:

FAILED TO PRACTICE GOOD HAND HYGIENE WHEN DOING PERSONAL CARES TO PREVENT THE SPREAD OF INFECTION/S:

R28 was observed on 12/18/14 9:59 a.m. to be resting in bed. Nursing assistant (NA)-A and NA-B were in the process of checking R28 for incontinence before getting him up in the wheel chair. Both NA-A &B were observed to use hand sanitizer to cleanse hands then both donned gloves. NA-A proceeded to remove the urine and stool soiled pad and then used hand wipes to clean the stool from the buttock area. Continuing to wear the stool soiled glove NA-A continued to provide cares by touching R28s body while rolling from side to side, putting on clean incontinence pad, pulling pants up and then touching the EZ lift sling to position under R28. After completing these tasks NA-A removed the stool soiled gloves and helped lift R28 with the EZ lift to the wheel chair.

During an interview with the director of nursing on December 19, 2014 at 1:00 p.m. she said the nursing assistants are educated to change gloves when soiled with stool or secretions before completing cares.

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an established Infection Control Program designed to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

1)
a. NA-A was re-educated with Director of Nursing on the practice of proper hand hygiene when completing personal cares. All nursing department staff have also been re-educated regarding hand washing and changing of gloves between cares per facility Infection Control Policy.
b. Facility policies related to infection monitoring (Upper Respiratory Infection, Infection Control Surveillance, Facility Outbreak, and Infection Control) for residents has been reviewed and updated by Director of Nursing and Infection Control RN. Re-education has been completed with nursing staff on reporting and monitoring of respiratory infection signs and symptoms. Infection Control RN will track residents that are exhibiting any signs and symptoms on infection control log.
c. Facility UTI Policy was reviewed and revised by Director of Nursing. Director of Nursing will complete re-education with licensed nurses regarding monitoring for signs and symptoms of UTI, the need for three signs and symptoms present prior to obtaining an order from physician for urinalysis. Nursing will monitor resident s infection using Infection Report sheet after initiation of antibiotic treatment.

2) All residents at Kenyon Sunset Home

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F 441	Continued From page 41 FAILED TO TRACK RESPIRATORY ILLNESS AS PART OF INFECTION CONTROL PROCESS: R16 was admitted to the facility on 1/7/08. List of active diagnoses from the facility ' s disease index report printed on 12/18/14 included: hypertension, diabetes, dementia, and CHF. During an observation on 12/15/14, at 10:35 a.m., R16 had a dry cough. During the interview resident demonstrated shortness of breath after several sentences and had audible nasal congestion. R16 stated she had a cold. R16's Medication administration record (MAR) indicated resident was administered Robitussin cough syrup twice per day for cough. R16's Nursing notes were reviewed from the time period of 12/15/14 to 12/18/14 and the nursing notes lacked physical assessment of chronic cough versus cold symptoms resident had displayed. Nursing notes also lacked monitoring of acute cold symptoms and documentation the medical doctor (MD) and/or the nurse practitioner (NP) had been notified of cold symptoms. R18 was admitted to the facility on 1/3/08. List of active diagnoses from the facility's disease index report printed on 12/18/14 included: memory loss, hypertension, and dementia with Lewy Bodies. During an observation on 12/15/14, at 10:32 a.m., R16 had very large copious amounts of yellow/green sputum coming from her left nostril. R16 had a cough. During an interview on 12/15/14, at 10:35 a.m., nursing assistant (NA)-G stated R16 started to cough last night. During an observation on 12/16/14, at 10:18 a.m. R16 was heard coughing. Cough sounded loose and wet. R18 again had copious amounts of yellow/green sputum that was coming out of her nose. Respiratory effort was labored. During an interview on 12/18/14, at 12:57 p.m.	F 441	have the potential to be affected by this deficient practice. 3) a. Kenyon Sunset Home will continue to re-educate individual staff as needed on proper hand hygiene as well as provide group education on hand hygiene and infection control at in-services and staff meetings and as needed. Hand hygiene skills testing will also be completed with nursing staff annually. b. Director of Nursing will implement a nurses meeting regularly to discuss residents status and any signs or symptoms of infection. Infection control nurse will also attend meeting and will initiate log used to track resident symptoms, treatment and patterns of infections such as respiratory illness. c. Director of Nursing will implement a nurses meeting regularly to discuss residents status and any signs or symptoms of infection. Infection control nurse will also attend meeting and will initiate log used to track resident symptoms, treatment and patterns of infections such urinary tract infections. 4) a. Hand washing audit will be completed monthly in the nursing department and reviewed with DON, Infection Control designee and Safety Committee facilitator. b. Director of Nursing will complete weekly infection control audit for duration of six months to ensure that proper tracking of resident infection is being	

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F 441	Continued From page 42 NA-A stated R16, " Did not feel well and started to get cold symptoms yesterday with a cough and yellow and green snot [mucus], but isn't sick." R18's nursing notes were reviewed from 12/15/14 to 12/18/14. Progress notes revealed last vital signs (blood pressure, temperature, respirations, and heart rate) were obtained on 12/17/14, two days after R18 showed signs and symptoms of an upper respiratory infection. Progress notes had no mention of cold symptoms or possible respiratory illness, and no documentation MD/NP was notified of change of condition. Medication administration record did not reflect medication was given to R18 to help alleviate or treat cold symptoms. R33 was admitted to the facility on 12/11/13. List of diagnoses from the facility's disease index report printed on 12/18/14 included: asthma, hypertension, edema, and anxiety. During an interview on 12/16/14, at 1:30 p.m. R33 was coughing. R33 complained of left side pain from coughing for several days. R33 stated had taken cough syrup however had to ask the nurse. R33 stated there had been a lot of sick people recently and the flu had been in the assisted living which is attached to this place. R33's nursing notes were reviewed and revealed lack of ongoing assessment, monitoring, and follow-up for cold symptoms. Documentation did not reflect MD/NP had been made aware of the R33's change of condition. Medication administration records revealed R33 had been administered cough syrup daily since 12/1/14. During an interview on 12/18/14, at 10:00 a.m., NP-A stated her expectation would be to report any change in condition including colds, coughs, or fevers. NP-A stated expectation is for the facility to monitor the resident by assessing lung sounds, blood, pressures, and vital signs.	F 441	completed per facility Infection Control Surveillance Policy. c. Director of Nursing will complete weekly infection control audit for duration of six months to ensure that proper tracking of resident infection is being completed per facility Infection Control Surveillance Policy. 5) Completion Date: January 23, 2015	

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	245379	A. BUILDING ______ B. WING ______	12/19/2014

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F 441	Continued From page 43	F 441		

During an interview on 12/18/14, at 4:33 p.m., registered nurse (RN)-A stated, illnesses that do not require antibiotics are not monitored or tracked by infection control. This includes respiratory illnesses.
Document review of infection control logs received from the facility had revealed no tracking, surveillance, and root cause analysis of the data to rule out Influenza and other contagious respiratory illnesses, or plan for containment of respiratory illness for R16, R13 & R18.
Facility policy/procedure Upper Respiratory Infections dated 5/23/11 read, "If you suspect a upper respiratory infection (URI) ..., Obtain resident vital signs, listen to lung sounds and collect any other data pertaining to current signs and symptoms of possible URI, Notify MD and/or NP of above data by fax or phone call., Nursing to monitor treatments, push fluids for 24 hours, complete the infection control sheet if an antibiotic was started, add URI information on the follow-up charting record, infection control registered nurse will monitor infection log and sheets to see if any patterns present themselves."
LACK OF THREE SIGNS AND SYMPTOMS OF A URINARY TRACT INFECTION (UTI) BEFORE STARTING AN ANTIBIOTIC & COMPLETING THE INFECTION CONTROL LOG TO DETERMINE IF ANTIBIOTIC WAS AFFECTIVE AND TO DETERMINE COURSE OF ACTION TO PREVENT UTIs FROM DEVELOPING:
R17 was prescribed Keflex on 7/30/14 for a urinary tract infection (UTI) as documented on the infection control log provided by the facility. However, the log lacked surveillance, organism types, if antibiotic was affective.
R17's Admission Minimum Data Set (MDS)

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F 441	Continued From page 44 included diagnoses of: anemia, hypertension, and renal insufficiency. The MDS indicated no cognitive impairment, one assist for activities of daily living, and occasional urinary incontinence. R17's nursing notes were reviewed, nursing notes lacked consistent documentation of monitoring presence or absence of urinary tract infections (UTI) symptoms to determine effectiveness of the prescribed antibiotic. R19 was prescribed Cipro for UTI on 9/2/14 according to the infection control log. The log lacked surveillance, symptoms, date of culture, if antibiotic affective, and date the UTI was resolved. R19's admission MDS included diagnosis of diabetes and dementia. The MDS indicated severe cognitive impairment, extensive assist of two staff for most activities of daily living, occasional urinary incontinence and frequent bowel incontinence, and R17's medications included a diuretic. R19's nursing notes were reviewed, nursing notes lacked consistent documentation of monitoring presence or absence of UTI symptoms to determine effectiveness of the prescribed antibiotic. Nursing notes also indicated the antibiotic was changed but no reason for changing the medication. R9997's nursing notes indicated the start of Amoxicillin (antibiotic) 500 milligrams (mg) three times a day for 10 days on 2/27/14 for diagnosis of a right ear infection and sinus infection. Nursing documentation revealed resident was also tested for UTI in the absence of documented symptoms and the Amoxicillin would cover the UTI as well. Nursing notes did not address monitoring for signs or symptoms of antibiotic effectiveness. The nursing notes did not address UTI during the	F 441		

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F 441	Continued From page 45 antibiotic course. The infection control log lacked on set of infection, date of culture, if antibiotic was affective. R9998's nursing notes indicated Cipro (antibiotic) 500 mg two times a day was started on 3/23/14. The antibiotic was started in the absence of at least three documented signs and symptoms of a UTI. Nursing notes lacked consistent documentation of monitoring presence or absence of UTI symptoms to determine effectiveness of the prescribed antibiotic. The infection control log lacked surveillance, symptoms, and if antibiotic was affective. During an interview on 12/18/14, at 4:33 p.m., RN-A stated the MD/NP did not require 3 symptoms to be present prior to the starting an antibiotic. RN-A stated there was a lack of infection control surveillance monitoring for UTIs. Facility policy/procedure Urinary Tract infections dated 5/23/11 read, "It is the policy of Kenyon Senior Living to monitor residents for urinary tract infections., Chart three symptoms of UTI from observations in the nurse's notes, push fluids for 24 hours., and add the urinary tract infection information on the follow-up charting record " Facility policy Infection Control Surveillance Policy dated 6/10/11 read, "It is the policy of Kenyon Sunset home to perform routine surveillance of residents, staff, and the environment. The primary purpose of infection control is the collection of information to ensure that precautions are in place or implemented or necessary measures are taken to prevent the spread of infection." The policy indicated the infection control nurse was responsible for monitoring the infection control log sheets, and the safety committee was responsible for monthly audits.	F 441		

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F 441	Continued From page 46 Facility policy/procedure Monitoring of Employee Illness dated 9/10/14 read, "It is the policy of Kenyon Senior Living to track and monitor employee illness to keep both our staff and our residents healthy., Infection control nurse will log employee illness signs and symptoms as well as any diagnosis, reporting date and return to work date. However, the policy lacked procedures for monitoring of residents who may have been exposed to ill staff members.	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245379	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**12/16/2014**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/19/2015

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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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Kenyon Sunset Home is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II (111) construction, with 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 1 additions met the construction type allowed for existing buildings and the facility was surveyed as one building. The nursing home is separated from both an assisted living facility and The Gunderson House by a 2-hour fire walls with opening protectives consisting of labeled, self-closing, 90-minute fire rated door assemblies. The facility is fully fire sprinkler as of 08/09/2013.	K 000		

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K 000	Continued From page 2 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 30 beds and had a census of 25 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72 - Section 7-3.2.1. The deficient practice could affect all 25 residents.. Findings include: On facility tour between 1:00 PM and 3:00 PM on 12/16/2014, the documentation review of the annual inspection and testing report by MN Conway, dated 8/13/2014, revealed there was no documentation for sensitivity testing that is to be done with-in one year after installation. A new fire alarm system was installed and tested	K 054	K 054 1) Kenyon Sunset Home will monitor the inspection, testing (including sensitivity testing) and maintenance for the smoke detector and fire alarm system. 2) Kenyon Sunset Home completed the sensitivity testing of the fire alarm system on January 15, 2015. 3) Director of Maintenance, David Floren, is responsible for correction, completion, and monitoring of the smoke detector and fire alarm system in coordination with Summit Companies.	1/15/15

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K 054	Continued From page 3 on 08/16/2013. 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 054		