Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Sunset Homes Assisted Living
3686 Kenosha Drive Northwest
Rochester, MN 55902
Olmsted County

Report #: HL26018002

Date: January 23, 2015

Date of Visit: November 5, 2014
Time of Visit: 8:00 a.m. – 4:00 p.m.

By: Lisa Jacobsen R.N., Special Investigator
Darin Hatch, Special Investigator

Type of Facility:

☐ Nursing Home ☐ HHA ☒ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: ____________

☐ Facility Self Report ☒ Complaint

Allegation(s): **It is alleged** that a client was neglected when staff failed to adequately supervise the client. The client went missing for 3 ½ hours and was found in a wooded area.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)

- [ ] State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- [x] State Licensing Rules for Home Care (MN Rules Chapter 4668)
- [ ] State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- [x] State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- [x] State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

The preponderance of evidence established that neglect of supervision occurred when the facility failed to provide the client with supervision and the client wandered from the facility unsupervised three times over an approximate six-week period of time.

The client had dementia and a history of wandering behaviors at the facility the client resided at prior to admission. The client's care plan indicated that the client may wander and staff were to check on the client hourly.

The facility was located in a wooded rural setting on a gravel road. The facility had two levels with bedrooms upstairs and on the main level for a total of four exits to the outside. One exit door to the outside was upstairs, and the remaining three exit doors to the outside were located on the main level. Cameras were observed throughout the facility but were not operational. Alarms were on several exit doors, but were not working. The client's bedroom was located upstairs.

Six clients resided at the facility with one staff person on duty each twelve-hour shift to care for the six clients. Staff indicated the client frequently tried to leave the facility because the client was confused, wanted to see his/her spouse. Staff indicated the client required constant monitoring and intervention to prevent her/him from going outside. Staff interviews revealed inconsistencies as to how frequent staff were to check on the client. Responses ranged from every fifteen minutes to every two hours.

Three days after the client was admitted to the facility, the client left the facility and was found approximately 30 minutes later, by a family member, walking a half mile away from the facility, on a rural gravel road that leads to the facility, unsupervised. Staff indicated after the incident, they were instructed by the administrator to continue to monitor the client for wandering behaviors and intervene to keep the client safe.

Eight days later, the client left the facility and was found in the nearby woods approximately 30 minutes later. The client walked away from the facility when staff went to use the phone. The staff indicated s/he asked other clients to watch the client while the staff person went to use the phone. Staff indicated after the incident, they were instructed by the administrator to continue to monitor the client for wandering behaviors and intervene to keep the client safe.

Approximately six weeks after the client was admitted to the facility, the client left the facility when staff were providing cares to other clients. The client was found in the nearby woods approximately 2 hours later. The client walked away from the facility through two unlocked service doors to the garage. Staff noticed the client's cane by the service door and noted the client was missing after a search of the building. The police were notified by the family of the client to assist in the search. The family discharged the client from the facility. No injuries to the client were reported.

During the onsite visit, locks that required a key to unlock the door from the inside were observed on several doors throughout the facility, thus creating a barrier for clients to escape during a fire unless a key was available. Also noted during the onsite visit were missing and inoperative smoke detectors. These concerns were referred to the State Fire Marshal's office for review.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility was responsible for the neglect of supervision. There were system breakdowns related to providing adequate care and services according to a suitable plan for the client. The facility did not have adequate staffing and supervision to care for the client. Staff were inconsistent and unsure as to what the client's plan of care stated in relation to how frequent staff should check on the client's whereabouts. The facility did not have specific policies on how often to check on clients and the facility failed to follow its own policy on acceptance and retention of a client.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Not Met
The requirements under State Licensing Rules for Home Care (MN Rules Chapter 4668) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________
(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: ___________
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records

☒ Care Guide

☒ Medication Administration Records

☒ Treatment Sheets

☒ Facility Incident Reports

☒ Physician Progress Notes

☐ ADL (Activities of Daily Living) Flow Sheets

☐ Laboratory and X-ray Reports

☐ Physician Orders

☐ Social Service Notes

☒ Nurses Notes

☐ Meal Intake Records

☐ Activities Reports

☐ Weight Records

☐ Therapy and/or Ancillary Services Records

☒ Assessments

☐ Skin Assessments

☒ Care Plan Records

Other pertinent medical records:

☐ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☒ Police Report

Additional facility records:

☐ Resident/Family Council Minutes

☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc.

☒ Facility In-service Records

☒ Facility Internal Investigation Reports

☒ Facility Policies and Procedures

☐ Call Light Audits

☐ Other, specify: __________

Number of additional resident(s) reviewed: 1

Were residents selected based on the allegation(s)? ○ Yes ◉ No ○ N/A Specify: Observations made while at facility

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: The client was discharged from the facility.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ◉ Yes ○ No ○ N/A Specify: ________

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: ________

Did you interview the resident(s) identified in allegation: ◉ Yes ○ No ○ N/A Specify: ________

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 2

Interview with staff: ◉ Yes ○ No ○ N/A Specify: ________

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 8

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: No alleged perpetrator identified.

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued ________ ○ No

Were contacts made with any of the following:

☐ Emergency personnel ☒ Police Officers ☐ Medical Examiner ☒ Other: Specify State Fire Marshall

Observations were conducted related to:

☐ Wound Care ☐ Medication Pass ☐ Meals

☐ Personal Care ☒ Dignity/Privacy Issues ☐ Restorative Care

☒ Nursing Services ☒ Safety Issues ☒ Facility Tour

☐ Infection Control ☐ Cleanliness ☐ Injury

☐ Use of Equipment ☐ Transfers ☐ Incontinence

☐ Call Light ☒ Other: Fire Safety

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ◉ Yes ○ No Specify: Facility building and grounds

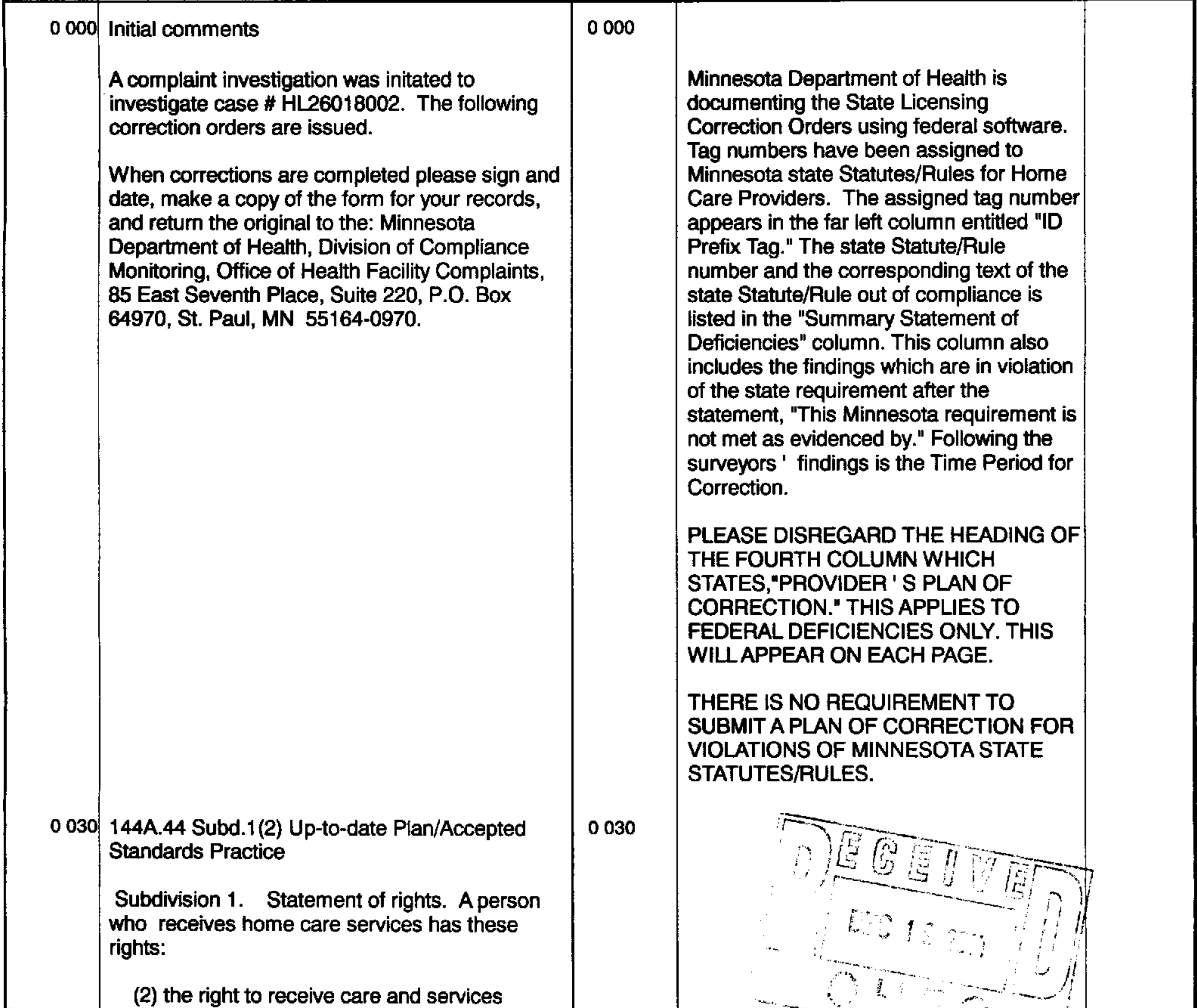
xc: Health Regulation Division – Home Care Assisted Living Program
Department of Public Safety-State Fire Marshal Division
Oronoco Police Department
Olmsted County Attorney
Olmsted County Sheriff's Office

PRINTED: 11/25/2014
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26018	A. BUILDING: ______ B. WING ______	C 11/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NORTHWEST ROCHESTER, MN 55902



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0 000	Initial comments A complaint investigation was initated to investigate case # HL26018002. The following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records, and return the original to the: Minnesota Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints, 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, MN 55164-0970.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state Statutes/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 030	144A.44 Subd.1(2) Up-to-date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services	0 030	RECEIVED DEC 18 201	

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

All orders completed.
Joseph Mcbunnm RN
12/18/14.

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0 030	Continued From page 1 according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to provide care and services according to a suitable plan for one of one client (C1) reviewed who had incidents of wandering away from the facility. The findings included: Observations on November 5, 2014 at 8:40 a.m., revealed the facility was a two level house with three bedrooms upstairs and four bedrooms on the main level. One exit door to the outside was upstairs, and the remaining three exit doors to the outside were located on the main level. There was also an exit door to the garage on the main level. Cameras were observed throughout the facility but were not operational. Alarms were on several exit doors, but were not working. C1's bedroom was located upstairs. The facility was located in the country on a gravel road and the back of the facility was surrounded by woods and farm land. Staffing records revealed that one staff person was scheduled to care for the six clients on each shift. C1's record was reviewed. Progress notes the	0 030		

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0 030	Continued From page 2 facility received from the nursing home the client resided at prior to admission to the home care provider indicated the client had frequent behaviors of wandering throughout the facility and into other clients' rooms. A progress note dated August 14, 2014 indicated the nursing home staff met with C1's family to discuss the client's behavior and possible referral to a secured unit. C1 was admitted to the facility on September 5, 2014 with a diagnosis of Lewy Body Dementia. A document that was titled, "ADL Description" dated September 5, 2014 and signed by the administrator/nurse indicated C1 walked with a walker, had partial or intermittent periods of disorientation and required "frequent intervention may wander, verbally abusive to others, removing or destroying property, cooperative with ADL's approximately 26% to 50% of time, may be resistant to redirection, low motivation or frequent mental health symptoms." C1's care plan dated September 5, 2014 indicated under special precautions "the resident may wander". Also noted under special instructions, "may wander - check hourly ". A progress note dated September 10, 2014 at 10:00 a.m. revealed C1 wandered from the facility and walked down the road. Staff were noted to have observed C1 leave the facility and were unable to redirect C1 back to the facility. C1 was picked up by C1's family member and returned to the facility. The note indicated that staff were to continue to redirect C1 and keep him safe. During an interview on November 14, 2014 at 2:03 p.m., the administrator/nurse stated the wandering incident occurred on September 8, 2014 at approximately 10:00 a.m. and that he	0 030		

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0 030	Continued From page 3	0 030		

was not informed of the incident until September 10, 2014, which is when he wrote the progress note.

When interviewed on November 5, 2014 at 12:35 p.m. family member-H indicated that she was on her way to the facility on the day of the incident (September 8, 2014) at approximately 10:30 a.m. when she saw C1 and the facility house dog walking down the road by the stop sign at the T in the road. (Investigators measured the distance from the facility to the T in the road to be approximately 0.5 miles.) Family member H returned C1 to the facility. Family member H spoke with the administrator and indicated she wanted to move C1 to another facility but was informed by the administrator that a GPS (Global Positioning Satellite) unit would be placed in C1's shoe and that the inoperative surveillance cameras would be made operational to keep C1 safe.

A progress note dated September 16, 2014 revealed C1 wandered from the facility by walking behind the garage when outside with another client. Staff attempted to locate C1 and later discovered him in the woods under a tree.

When interviewed on November 13, 2014 at 2:04 p.m. unlicensed staff person (ULP)-E said that C1 tried to go outdoors multiple times throughout the day. She stated that the front door and garage service doors were always unlocked during the day. ULP-E stated on September 16, 2014, at approximately 11:00 a.m., C1 asked for his wife so she went into the pantry to look for the wife's phone number. ULP-E said she asked other clients to keep an eye on C1 while she was in the pantry. C1 went outside while ULP-E was in the pantry and was missing for approximately 20

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0 030	Continued From page 4	0 030		

minutes. C1 contacted the administrator/nurse. The administrator found C1 outside.

When interviewed on November 5, 2014 at 12:35 p.m., Family member H indicated that she was went to the facility on September 16, 2014 at approximately 12:00 p.m. She stated that when she entered the facility, staff members informed her that C1 had wandered from the facility, was gone for approximately 30 minutes, and that staff had just found C1. She stated C1 walked out the main door when the staff person was busy and that the administrator never followed through with the promise of a GPS unit and operational surveillance cameras. In addition, Family member H mentioned the doors were supposed to be locked after the first incident of elopement with C1. She said she was also told by the administrator/registered nurse that a baby monitor would also be used to monitor C1's whereabouts.

A progress note dated October 22, 2014 revealed C1 wandered from the facility on October 21, 2014 at approximately 2:00 p.m. by walking out the garage service door.

When interviewed November 13, 2014 at 2:04 p.m., ULP-E stated on October 21, 2014 at approximately 2:30 p.m., she discovered that C1 was missing after she went to check on C1's whereabouts after providing cares to another client. She stated she left the other clients alone while searching for C1. ULP-E stated she called the administrator/nurse who came to the facility to assist in the search. ULP-E stated the administrator found C1 in the woods but was not sure how long he had been missing.

When interviewed on November 5, 2014 at 12:35

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0 030	Continued From page 5 p.m., Family member H indicated that she went to the facility on October 21, 2014 at approximately 3:30 p.m. and was informed by staff that C1 had wandered from the facility by walking out the garage service doors. She assisted in searching for C1 along with another client of the facility. Family member H indicated that the police had also been notified by a family member to assist in the search. C1 was found in the woods behind the facility. The family decided to move C1 out of the facility immediately. When interviewed on November 7, 2014 at 11:34 a.m. ULP-A, said that C1 frequently tried to get out to look for his wife and that she had heard from other staff about C1 having similar behavior with other staff. When interviewed on November 7, 2014 at 12:06 p.m. ULP-B, said that C1 frequently tried to get out to look for his wife and that he had heard from other staff about C1 having similar behavior with other staff. He said the doors were unlocked most of the time so other residents could go outdoors to smoke. When interviewed on November 7, 2014 at 2:06 p.m. ULP-C said that C1 liked to go outside to look for his wife and that C1 got anxious when his family did not show up to visit. C1 would then attempt to leave the facility and look for his family. She said the doors to the outside were only locked at night. When interviewed on November 13, 2014 at 2:52 p.m. ULP-F said that C1 frequently tried to get out to look for his wife as much as 6 times per day and that the front door and garage service doors were always unlocked during the day.	0 030		

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0 030	Continued From page 6 When interviewed on November 14, 2014 at 9:02 a.m. ULP-I said that C1 frequently asked for his wife and would become frustrated. She said she was advised by the administrator to keep a close watch on C1 to keep him safe. She said the doors were always unlocked except during the overnight hours when she worked. When interviewed November 5, 2014 and November 14, 2014 at 3:20 p.m. and 2:00 p.m. respectively, the administrator/nurse stated the camera system he had installed had not been working for at least two months. In addition, the administrator/nurse stated several doors had an audible alarm installed that alarmed when opened, but the alarms were not always turned on, because sometimes the alarm did not stop beeping. The administrator/nurse indicated that dead bolt locks that required a key to open them on the inside were placed on the exit doors at some time during C1's stay. The administrator/nurse indicated that he "overreacted" by putting the dead bolts on, but wanted to keep C1 safe. The administrator/nurse stated he did the best he could to keep C1 safe. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 030		
0 605	626.557 Subd.3 Timing of report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an	0 605		

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0 605	Continued From page 7 individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or	0 605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26018	A. BUILDING: ______ B. WING ______	C 11/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NORTHWEST ROCHESTER, MN 55902

(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) COMPLETE DATE
0 605	Continued From page 8 facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report to the common entry point, three of three incidents of a client (C1) wandering from the facility. The findings included: C1's record was reviewed. C1 was admitted to the facility on September 5, 2014 with a diagnosis of Lewy Body Dementia. A document that was titled, "ADL Description" dated September 5, 2014 and signed by the administrator/nurse indicated C1 walked with a walker, had partial or intermittent periods of disorientation and required "frequent intervention may wander, verbally abusive to others, removing or destroying property, cooperative with ADL's approximately 26% to 50% of time, may be resistant to redirection, low motivation or frequent mental health symptoms." C1's care plan dated September 5, 2014 indicated under special precautions "the resident may wander". Also noted under special instructions, "may wander - check hourly ".	0 605		

Minnesota Department of Health

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0 605	Continued From page 9 When interviewed on September 5, 2014 at 12:35 p.m., Family Member-H. indicated that C1 wandered away from the facility on September 8, 2014 at approximately 10:30 a.m., September 16, 2014 at approximately 11:30 a.m., and on October 21, 2014 at approximately 2:00 p.m. A progress note dated September 10, 2014 at 10:00 a.m. revealed C1 wandered from the facility and walked down the road. Staff were noted to have observed C1 leave the facility and were unable to redirect C1 back to the facility. C1 was picked up by his family and returned to the facility. The note indicated that staff were to continue to redirect C1 and keep him safe. During an interview on November 14, 2014 at 2:03 p.m., the administrator/nurse stated the wandering incident occurred on September 8, 2014 at approximately 10:00 a.m. and that he was not informed of the incident until September 10, 2014, which is when he wrote the progress note. A progress note dated September 16, 2014 revealed C1 wandered from the facility by walking behind the garage when outside with another client. Staff attempted to locate C1 and later discovered him in the woods behind the facility under a tree. A progress note dated October 22, 2014 revealed C1 wandered from the facility on October 21, 2014 at approximately 2:00 p.m. by walking out the garage service door and was later found in the woods behind the facility. When interviewed November 14, 2014 at 2:00 p.m., the administrator/nurse confirmed that he did not report the three incidents of C1 wandering from the facility on September 8, 2014, September 16, 2014 and October 21, 2014. The	0 605		

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0 605	Continued From page 10 administrator/nurse stated in hindsight he should have reported the incidents of C1 wandering from the facility to the common entry point. Review of undated policies and procedures titled Vulnerable adult reporting and investigation policy revealed, "any staff who witnesses or suspects any form of resident maltreatment including self-neglect or resident-to-resident abuse must report the incident immediately to RN/DIRECTOR OF NURSING SERVICES". The policy further states that the RN/ the director of nursing shall immediately make an oral report to the CEP. "Immediately means as soon as possible, but no longer than 24 hours from the time the director of nursing received initial knowledge that the incident has occurred." The policy also states that if the director of nursing is unsure whether reportable maltreatment has occurred, the director of nursing will make an oral report to the CEP. Review of undated policies and procedures titled Missing Client revealed if the client's absence was not planned the RN will call the common entry point immediately within 24 hours. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 605		
01355	4668.0019 Advertising 4668.0019 Advertising. Licensees shall not use false, fraudulent, or misleading advertising in the marketing of services. For purposes of this part, advertising includes any means of communicating to potential clients the availability, nature, or terms of home care services.	01355		

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01355	Continued From page 11	01355		

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the licensee used false and misleading advertising in the marketing of services for one of one client (C1) reviewed. The findings included:

An advertising brochure provided by the administrator/nurse on November 5, 2014 which was dated 2009-2010 indicated the following, "The whole facility is fully equipped with surveillance system to monitor 24-7." In addition, the brochure indicated under Services Offered, "provides 24 hours, seven days a week security surveillance to the building."

The licensee's website (http://sunsethomesliving.com/Services.html), which advertised the home care services provided, was printed off the website by the investigator on October 30, 2014 at 12:25 p.m. Under the topic "Basic Services", it indicated "24 hour monitoring system of entrance/exit."

Observations during the onsite visit on November 5, 2014 at approximately 8:40 a.m., revealed the following, Exit doors to the outside of the facility were deadbolt locked requiring key access to unlock them from the inside, several doors had an audible electronic monitoring devices on them but they were not turned on and/or functioning, and a camera system was installed, but was not operational.

When interviewed November 14, 2014 at 2:00 p.m., the administrator/nurse confirmed the facility did not currently have a 24 hour security

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01355	Continued From page 12	01355		

surveillance system. The administrator/nurse stated the camera system had not been working for at least two months. In addition, the administrator/nurse stated several exit doors had audible alarm installed on the door that alarmed when opened, but the alarms were not always turned on, because sometimes the alarm did not stop beeping.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

01435 — 4668.0050 Subp.1 Acceptance of clients — 01435

Subpart 1. Acceptance of clients.

No licensee may accept a person as a client unless the licensee has staff, sufficient in qualifications and numbers, to adequately provide the services agreed to in the service agreement, under part 4668.0140 for class A, B, and C licensees, or the service plan, under part 4668.0815, for class F home care provider licensees.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the licensee accepted a client that they did not have sufficient staff to adequately provide the services agreed to in the service plan for one of one client (C1) reviewed. The findings included:

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01435	Continued From page 13	01435		

C1 wandered away from the facility on September 8, 2014, September 16, 2014, and October 21, 2014.

C1's record was reviewed. Progress notes from the nursing home the client resided at prior to admission to the home care provider indicated the client had frequent behaviors of wandering throughout the facility and into other clients' rooms. A progress note dated August 14, 2014 indicated the nursing home staff met with C1's family to discuss the client's behavior and possible referral to a secured unit.

C1 was admitted to the facility on September 5, 2014 with a diagnosis of Lewy Body Dementia. A document titled, "ADL Description" dated September 5, 2014 and signed by the administrator/nurse indicated C1 walked with a walker, had partial or intermittent periods of disorientation and required "frequent intervention may wander, verbally abusive to others, removing or destroying property, cooperative with ADL's approximately 26% to 50% of time, may be resistant to redirection, low motivation or frequent mental health symptoms."

Review of C1's service agreement dated September 5, 2014 signed by the administrator indicated C1 required "frequent intervention may wander". The service agreement also indicated that C1 was both physically and mentally unable to self-preserve in event of an emergency or harmful situation. Review of C1's care plan dated September 5, 2014 indicated under special precautions "resident may wander" and under special instructions "may wander-check hourly". In addition, the goals listed on C1's care plan stated the facility was to "assure safety, comfort, & cleanliness."

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01435	Continued From page 14	01435		

When interviewed on November 5, 2014 at approximately 8:40 a.m. the administrator/nurse revealed one staff member was on duty on each shift to care for the six clients.

When interviewed on September 5, 2014 at 12:35 p.m. Family Member H indicated that C1 wandered from the facility three times during the six weeks the client resided at the facility.

A progress note dated September 10, 2014 at 10:00 a.m. revealed C1 wandered from the facility and walked down the road. Staff were noted to have observed C1 leave the facility and were unable to redirect C1 back to the facility. C1 was picked up by his spouse and returned to the facility. During an interview on November 14, 2014 at 2:03 p.m., the administrator/nurse stated the wandering incident occurred on September 8, 2014 at approximately 10:00 a.m. and that the administrator/nurse was not informed of the incident until September 10, 2014, which is when he wrote the progress note.

When interviewed on November 5, 2014 at 12:35 p.m. family member-H indicated that she was on her way to the facility on the day of the incident (September 8, 2014) at approximately 10:30 a.m. when she saw C1 and the facility house dog walking down the road by the stop sign at the T in the road. (Investigators measured the distance from the facility to the T in the road to be approximately 0.5 miles.) Family member H returned C1 to the facility

When interviewed November 13, 2014 at 2:04 p.m., unlicensed staff person (ULP)-E stated C1 was impulsive and attempted to leave the facility multiple times during a shift. ULP-E stated on

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01435	Continued From page 15 September 16, 2014, she went to another room to look up a telephone number and was gone for approximately two minutes. When ULP-E returned, C1 was gone. ULP-E searched outside but could not find C1 and telephoned the administrator/nurse, to report C1 had left the facility. The administrator/nurse arrived approximately twenty minutes later and found C1 in the woods in the back yard. ULP-E stated on October 21, 2014 in the afternoon, C1 was sitting at a table having coffee. ULP-E went to assist another client with cares and was gone for approximately ten minutes. When ULP-E returned to check on C1, the client was gone. ULP-E went outside to search for C1, then called the administrator/nurse, who arrived in approximately twenty minutes. The administrator/nurse found C1 in the woods. When interviewed November 14, 2014 at 2:00 p.m., the administrator/nurse stated he did his best to keep C1 safe. The administrator/nurse stated he felt the nursing home kept him "in the dark" regarding C1's behaviors. The licensee's policy titled Acceptance and Retention of a Client which was undated, revealed under "Procedure: 1. Eligibility for our assisted living services, to be a client of our program, a person must e) not exhibit behaviors that endanger self, other residents or staff." TIME PERIOD FOR CORRECTION: Fourteen (14) days	01435		
06120	4668.0815 Subp. 4 Contents of Service Plan Subp. 4. Contents of service plan. The service plan required under subpart 1 must include:	06120		

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06120	Continued From page 16 A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1; B. the identification of the persons or categories of persons who are to provide the services; C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any; D. the fees for each service; and E. a plan for contingency action that includes: (1) the action to be taken by the class F home care provider licensee, client, and responsible person if scheduled services cannot be provided; (2) the method for a client or responsible person to contact a representative of the class F home care provider licensee whenever staff are providing services; (3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition; (4) the method for the class F home care provider licensee to contact a responsible person of the client, if any; and (5) the circumstances in which emergency	06120		

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06120	Continued From page 17 medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that the contents of the service plan met the requirements under the law for one of one client (C1) reviewed. The findings included: C1's service plan was reviewed. A document titled, "Admission and Service Plan Agreement" dated September 5, 2014 was reviewed. The document included an assessment of the client's needs but did not include a description and frequency of the home care services to be provided, nor did it include the identification of the persons or categories of persons who would be providing the services. The document did not include the schedule or frequency of supervision required by law. In addition, the document did not include the fees for each service. The document had an area titled, "Rate Calculation", but it was not filled out. The document did not include a plan for contingency action that included the action to be taken by the home care provider licensee, client, and responsible person if scheduled services cannot be provided. The document titled, "Admission and Service Plan Agreement" dated September 5, 2014 included an area titled, "Assessment and Service Agreement Development". Under this area, it indicated the following: "A registered nurse (RN) conducts an assessment of the client at or prior	06120		

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06120	Continued From page 18 to moving in to Sunset Homes Assisted Living HWS. Based upon this assessment, your physician orders and your contribution, the RN will develop a service plan. This plan must be complete within 14 days of admission." When interviewed November 14, 2014 at 2:00 p.m., the administrator/nurse confirmed the "Admission and Service Plan Agreement" did not include the required information. The administrator/nurse stated the county approved this service agreement, but stated he did not understand that there were additional requirements by the State. TIME PERIOD FOR CORRECTION: Fourteen (14) days	06120		

AH Form Approved
1/26/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H26018	A. Building B. Wing	1/20/2015

Name of Facility	Street Address, City, State, Zip Code
SUNSET HOMES ASSISTED LIVING	3686 KENOSHA DRIVE NORTHWEST ROCHESTER, MN 55902

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 00030 Reg. # 144A.44 Subd.1(2) LSC	Correction Completed 01/20/2015	ID Prefix 00605 Reg. # 626.557 Subd.3 LSC	Correction Completed 01/20/2015	ID Prefix 01355 Reg. # 4668.0019 LSC	Correction Completed 01/20/2015
ID Prefix 01435 Reg. # 4668.0050 Subp.1 LSC	Correction Completed 01/20/2015	ID Prefix 06120 Reg. # 4668.0815 Subp. 4 LSC	Correction Completed 01/20/2015	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

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
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
11/21/2014			