| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245379 | A. BUILDING _____ B. WING _____ | 03/05/2020 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0584<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br><br>Based on observation and interview, facility failed to provide a comfortable and homelike environment for 1 of 2 residents (R8) observed with broken furniture. Findings include: During an observation and interview on 3/3/20, at 1:22 p.m. R8's footboard was cracked extending from one side of the board horizontally to the opposite side the width of the board. A section of the board (wood) about six inches long and 1/2 inch wide was missing and was rough to the feel. The crack had been mended using several large, steel T-plates with multiple screws on each one. The T-plates and screws were visual located on the inside of the footboard. R8 said, I kick the hell out of it (footboard). R8 also stated the footboard had been in condition for several years. According to an interview, on 3/04/20, at 1:36 p.m. the maintenance director (MAINT) stated there was a folder at the nurses' station where staff could write a note about any needed repairs, but they also would report to him in the hallway. He stated the members of the maintenance crew tried to stay out of resident rooms unless they received a report of an item needing repair. MAINT did not recall a broken footboard being reported during the four years he had worked at the facility, but stated a footboard split across the width of it should be replaced. MAINT stated repair work should not be done leaving screws on the side where they might be against resident skin. MAINT went to R8's room and confirmed the footboard was repaired with screws on the resident side. According to an interview 3/4/20, 1:45 p.m. the director of nursing (DON) stated there was a potential for injury with repair hardware being located on the inside of the footboard. DON stated, I think we can just replace this. A request was made for any facility documentation of regular auditing for broken items or maintenance issues in resident rooms in the facility. The facility provided audits of six rooms with a note indicating room audits had been started in 2020 and had not been previously documented. R8's room was not included. |
| F 0679<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide activities to meet all resident's needs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interviews and record review, the facility failed to assess meaningful individual activities and document the activities for 1 of 1 resident's (R5) reviewed for activities. Findings include: R5's Face Sheet and [DIAGNOSES REDACTED]. According to R5's care plan, a problem dated 1/24/20, she was to be involved in 1-4 activities and/or one to one activities a week. Interventions included provide materials of interest: music, baby dolls, stuffed animals, fidget blanket. and inform resident of upcoming activities by providing calendar, verbal reminders, escort and encouragement. According to an interview 3/04/20, 9:06 a.m. a family member (FM)-A stated R5 had enjoyed traveling when she was younger and raised and trained dogs. FM-A stated R5 enjoyed attending music activities. During an interview on 3/05/20, at 12:31 p.m. the facility social worker SW stated she was also the certified activity director for the facility and planned the activity schedule. SW stated she had assistance with implementation of the activities by an activity aide (AA)-B and nursing assistants (NA) who would perform one to one activities. SW stated AA-B was responsible to document resident attendance at activities. SW stated an expectation that documentation be completed if a resident attends an activity, but to document asleep if they sleep when at the activity. If an activity is offered and a resident declines to attend, SW stated that should be documented as well. SW stated one to one activities should include documentation of what type of activity was offered, the length of time and the resident's response. R5's activity attendance for March 2, 3 and 4 indicated Bible Study on 3/4/20 and Bingo 3/4/20 but slept through it. According to the facility activity calendar, Bible Study was held at 10:10 a.m. but observation of R5 was in her room with FM-A. The calendar read bingo was held at 2:45 p.m. but an observation of R5 was in her room, in her recliner putting her legs over the arm of the chair and picking at her blankets. According to the facility activity calendar, a music activity was provided on 3/3/20, 11:00 a.m. and 3/5/20, 11:15 a.m. According to R5's activity attendance sheet, R5 was marked as having attended a music activity on 3/2, 3/3 and 3/4/20 which did not correlate with the facility calendar. R5's attendance record indicated she had attended, but slept during crafts/arts on 3/2 and 3/3/20; however, the facility calendar did not indicate crafts or arts were provided as an activity. R5's activity attendance record indicated R5 was independent in news on 3/3 and 3/4/20. The record also had a check mark by lounge a.m. group and lounge p.m. group for 3/2, 3/3, and 3/4/20, as well as going for wheelchair walks on each of those days, watching television in her room on those days and sitting in a sunny hall/lobby. An additional page in R5's attendance file was reviewed for the types of one to one activities, the time engaged in the activity and R5's response. The page did not include any recent documentation over the past few months. During the interview 3/5/20, 12:31 p.m. SW confirmed that R5 was not capable of independently attending to the news. SW confirmed R5 could not have attended music on all the dates listed on her attendance record as music was not provided, and generally, music playing in the background was not considered an activity. SW stated lounge groups were usually held when residents indicated a wish to gather with other residents in the lobby area to socialize. SW stated residents had generally been spending more time in their rooms so no gatherings had occurred. SW stated assisting a resident to and from their room to dining room was not considered a wheelchair walk and was unable to confirm a wheelchair walk had occurred as this would be movement to the assisted living portion of the building to observe activities or visit there, or going outside. SW stated it was important to document activity attendance accurately so she could assess the effectiveness of the activity plan to best meet resident needs. Facility policy titled Kenyon Senior Living Activities and dated 7/31/2007 and last updated 2/2/2011, indicated to provide a program of activities designed to meet the interests and needs and promote optimal physical, mental and psychosocial well-being of each resident and involvement would be kept and available for review by physicians, nursing, administrators, SW and survey team. |
| F 0758<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and document review, facility failed to provide rationale for extending a PRN anti-psychotic order beyond 14 days and also failed to indicate for use of that medication for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include: R11's medical record Face Sheet and [DIAGNOSES REDACTED]. According to Minimum Data Set |

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

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 0758<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>(MDS) comprehensive assessment dated [DATE], R11 was cognitively impaired, required extensive assistance to total dependence on staff for all activities of daily living. The MDS indicated R11 exhibited behaviors such as throwing food, disrobing in public, hitting or scratching herself and making disruptive sounds daily. The MDS indicated R11 also made behavioral verbalizations against others every 1 to 3 days, but she did not exhibit [MEDICAL CONDITION] or hallucinations. The MDS indicated R11's behaviors did not place her at risk of injury but the behaviors were worsening. According to the medical record physician's orders [REDACTED]. On 2/6/20 that order was discontinued and replaced by an order that read: [MEDICATION NAME] 2 mg/mL, administer 0.5mg or 0.25mL sublingually every 6 hours PRN for agitation, tremors and anxiety; however, added to the order was a statement that said needed indefinitely for [MEDICAL CONDITION]/tremors/anxiety A medication informed consent form for benzodiazepine's ([MEDICATION NAME] being in that drug category) and signed by R11's family on 4/8/19 indicated the reason for the medication and benefit was for the potential quicker relief of tremor symptoms. According to R11's care plan, a problem dated 2/24/20 indicated R11 had frequent episodes of verbal, non-aggressive behaviors of yelling out that were not directed towards others. The problem statement indicated behaviors may be related to communication difficulties, fear and anxiety. An associated intervention was to administer [MEDICATION NAME]. A problem statement dated 4/8/19 indicated R11 was at risk for adverse consequences related to the use of antipsychotic medication for treatment of [REDACTED]. An associated intervention indicated R11 was to receive an antipsychotic, [MED] for the listed behaviors and [MEDICATION NAME] as ordered. According to an interview, 3/05/20, 10:01 a.m. the director of nursing (DON) stated that R11 would experience tremors as a consequence of increased anxiety. DON stated the [MEDICATION NAME]/[MEDICATION NAME] had originally been ordered for tremors as the only indication for administration, but said the medical provider did not want to adjust the medication dose to a higher level simply based on the existence of tremors. DON stated there had never been any identified physical cause of R11's tremors so they began to document on R11's other behaviors. The medical provider then changed the indications for use to include agitation and anxiety. DON confirmed the medical provider had received a pharmacy recommendation in December 2019 to limit the PRN [MEDICATION NAME] to a 14 day period or provide justification for extending the order beyond 14 days. DON stated the justification provided to extend the PRN to exclude a stop date was because R11 had tremors, agitation and anxiety. DON was unable to differentiate between justification for the order extension and indication for administration of medication dose. DON stated she was unaware that [MEDICAL CONDITION] had been added to the indication for use of [MEDICATION NAME] and said [MEDICAL CONDITION] must be a new diagnosis. DON was not aware of R11 having any recent [MEDICAL CONDITION], and stated<br>they were not currently monitoring R11 for [MEDICAL CONDITION] activity. From 2/1/20 through 2/5/20, R11 received four PRN doses of [MEDICATION NAME] for the following reasons, yelling (documented 4 times), hitting (once), agitation, not described (twice). No incidence of tremors or anxiety were documented. No orders indicated the medication should be given for yelling or hitting. From 2/6/20 through 2/29/29, R11 received 15 PRN doses of [MEDICATION NAME]. The following reasons for giving the medication were documented: yelling (documented 14 times), hitting, kicking behaviors towards staff (four episodes), agitation (9 episodes) and anxiety (2 episodes). No incidence of tremors or [MEDICAL CONDITION] were documented. Again, the new order did not indicate the medication was to be given for yelling or hitting, kicking behaviors toward staff. Between [DATE] and 3/5/20, R11 received two doses of the medication which were again documented as for yelling out, but also for agitation. According to R11's behavioral documentation records, R11 was receiving the [MEDICATION NAME] for tremors and anxiety; however, the behavior listed to be monitored was agitation and yelling. Anxiety was written in by hand on each sheet. The sheets did not indicate tremors were being monitored. A request was made for a policy related to [MEDICAL CONDITION] medication use. Facility provided a document titled Kenyon Senior Living Use of [MEDICAL CONDITION]<br>Medications dated [DATE]08 and last updated 1/2[DATE]9. The policy indicated a resident will not receive [MEDICAL CONDITION] medication unless such a medication is needed to treat a specific condition and each [MEDICAL CONDITION] medication will be given to treat clearly defined target behaviors. |
| F 0947<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and document review, the facility failed to monitor the completion of 12 hours of annual in-service training was completed by 4 of 5 nursing assistants (NA-A, NA-B, NA-C, NA-D) whose education records were reviewed. Additionally, the facility failed to ensure 4 of the 5 NA staff (NA-B, NA-C, NA-D, NA-E) completed required dementia training. Findings include: A request was made for the education records of five randomly selected NAs who had worked in the facility for more than one year. The facility supplied a print out of their Healthcare Academy on-line training transcripts for NA-A, NA-B, NA-C, NA-D and NA-E. A review of the records indicated the following: NA-A had completed 7 hours of training in the past year, NA-B had completed 10 hours of training in the last year, NA-C had completed 10 hours of training in the last year, NA-D had completed 10.75 hours of training in the last year and NA-E had completed 10 hours of training in the last year, with an additional 2 hours of in-house inservice attendance. A request was made for the education records of the selected staff s' dementia training.These records were reviewed for evidence of course completion by NA-A, NA-B, NA-C, NA-D and NA-E. The facility indicated an expectation for all direct care staff to complete dementia training covering four core areas. The facility failed to provide evidence of dementia training completion in the following subjects for the NAs as indicated below each core course: 1. Nursing Home [MEDICAL CONDITION] and Related Disorders. All listed NAs had completed this course. 2. Care of the Cognitively Impaired Resident. Those without evidence of training included- NA-B NA-C NA-E 3. Challenging Behaviors: Care & Interventions for Residents experiencing Dementia. The facility indicated this course also was used to cover the requirements for communication skills. Those without evidence of training included- NA-D According to an interview on 3/5/20, at approximately 4:00 p.m. the director of nursing (DON) stated the facility provided adequate hours of nursing assistant training through their on-line training platform, Healthcare Academy and also had additional training at times throughout the year. DON was able to identify that NA-E attended two additional training sessions, one on dementia care and one on fall prevention, and NA-B attended the fall prevention training. DON was unable to provide any additional documentation of NA training hours. DON provided a written list of courses offered in 2019 with a stated expectation that staff would complete quarterly topics. The facility made 27 hours of training available through the Healthcare Academy. |