

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5NKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00722

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245433		3. NAME AND ADDRESS OF FACILITY (L3) SYLVAN COURT (L4) 112 ST OLAF AVENUE SOUTH (L5) CANBY, MN (L6) 56220		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2) 490617900		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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) 06/30	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		6. DATE OF SURVEY 04/08/2013 (L34)		8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10. THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: ____ 1. Acceptable POC ____ 2. Technical Personnel ____ 6. Scope of Services Limit ____ 3. 24 Hour RN ____ 7. Medical Director ____ 4. 7-Day RN (Rural SNF) ____ 8. Patient Room Size ____ 5. Life Safety Code ____ 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)			
12. Total Facility Beds 68 (L18)		13. Total Certified Beds 68 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 68 (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 Brenda Fischer, Unit Supervisor (L19)	Date : 04/08/2013	18. STATE SURVEY AGENCY APPROVAL Colleen B. Leach, Program Specialist (L20)	Date: 04/10/2013
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u>X</u> 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 02/01/1987 (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 <u>00</u> INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS Posted 5/1/2013 ML	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 04/02/2013 (L33)		DETERMINATION APPROVAL	

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5433

Post Certification Revist by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Effective March 27, 2013, the facility is certified for 68 skilled nursing facility beds. Please refer to the CMS 2567B for both health and LSC.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5433

April 10, 2013

Ms. Nancy Salmon, Administrator
Sylvan Court
112 St. Olaf Avenue South
Canby, Minnesota 56220

Dear Ms. Salmon:

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 27, 2013, the above facility is certified for:

68 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 68 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,

A handwritten signature in black ink that reads "Colleen Leach". The signature is written in a cursive, flowing style.

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Ms. Nancy Salmon, Administrator
Sylvan Court
112 St. Olaf Avenue South
Canby, Minnesota 56220

April 10, 2013

RE: Project Number S5433023

Dear Ms. Salmon:

On February 28, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 15, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 8, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 21, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 15, 2013, effective March 27, 2013 and therefore remedies outlined in our letter to you dated February 28, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Colleen Leach". The signature is written in a cursive, flowing style.

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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 245433	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 4/8/2013
Name of Facility SYLVAN COURT		Street Address, City, State, Zip Code 112 ST OLAF AVENUE SOUTH CANBY, MN 56220

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 F0279 Reg. # 483.20(d), 483.20(k)(1) LSC _____	Correction Completed 03/27/2013	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 BF/cbl	Date: 04/10/2013	Signature of Surveyor: 10562	Date: 04/08/2013
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/15/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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 245433	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 3/21/2013
Name of Facility SYLVAN COURT		Street Address, City, State, Zip Code 112 ST OLAF AVENUE SOUTH CANBY, MN 56220

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 <u>K0017</u>	Correction Completed 02/25/2013	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0029</u>	Correction Completed 02/27/2013	ID Prefix _____ Reg. # NFPA 101 LSC <u>K0056</u>	Correction Completed 02/12/2013
ID Prefix _____ Reg. # NFPA 101 LSC <u>K0069</u>	Correction Completed 02/15/2013	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 PS/cbl	Date: 04/10/2013	Signature of Surveyor: 27200	Date: 03/21/2013
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/12/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5NKK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00722

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245433		3. NAME AND ADDRESS OF FACILITY (L3) SYLVAN COURT (L4) 112 ST OLAF AVENUE SOUTH (L5) CANBY, MN (L6) 56220		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 490617900		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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) 06/30	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		6. DATE OF SURVEY 02/15/2013 (L34)		8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: 2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
12.Total Facility Beds 68 (L18)		13.Total Certified Beds 68 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 68 (L37) (L38) (L39) (L42) (L43)	
15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)		16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.			

17. SURVEYOR SIGNATURE

Date :

Miriam Thornquist, HFE NEII

03/25/2013

(L19)

18. STATE SURVEY AGENCY APPROVAL

Date:

Colleen B. Leach, Program Specialist

04/01/2013

(L20)

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

19. DETERMINATION OF ELIGIBILITY ____ 1. Facility is Eligible to Participate ____ 2. Facility is not Eligible (L21)		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : _____	
22. ORIGINAL DATE OF PARTICIPATION 02/01/1987 (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) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. 03001 (L31)		30. REMARKS Posted 4/2/2013 ML	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9387

February 28, 2013

Ms. Nancy Salmon, Administrator
Sylvan Court
112 St Olaf Avenue South
Canby, Minnesota 56220

RE: Project Number S5433023

Dear Ms. Salmon:

On February 15, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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;

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:

Gail Anderson
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Telephone: (218) 332-5140

Fax: (218) 332-5196

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 March 27, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 15, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 15, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Sylvan Court
February 28, 2013
Page 6

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Gail Anderson". The signature is written in dark ink on a light background.

Gail Anderson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 332-5140 Fax: (218) 332-5196

Enclosure

cc: Licensing and Certification File

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

PRINTED: 02/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245433	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2013
NAME OF PROVIDER OR SUPPLIER SYLVAN COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 112 ST OLAF AVENUE SOUTH CANBY, MN 56220		
(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		F 000		
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.				
F 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		F 279	*Care plan for R49 has been updated by the DON and RN Care Coordinator to include the following: 1. Emergency care if bleeding/leaking, or signs of infection 2. Emergency call numbers to contact if issues with shunt or port 3. Identification of the tunneled catheter in the Rt. upper chest and the internal access shunt in the Lt. arm 4. Dialysis catheter site care 5. How blood draws will be completed 6. How flushing of the catheter will be completed 7. Bathing precautions R/T catheter 8. Identifying signs and symptoms of infection that nursing must monitor for *R49 will have also have a laminated list of these interventions in his room and copy will be placed in treatment book as well. Nursing staff will receive training on these	3/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Nancy Salmon

TITLE

Administrator

(X6) DATE

3/12/13

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NAME OF PROVIDER OR SUPPLIER SYLVAN COURT			STREET ADDRESS, CITY, STATE, ZIP CODE 112 ST OLAF AVENUE SOUTH CANBY, MN 56220		
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F 279	Continued From page 1 by: Based on observation, interview and document review, the facility failed to develop care plan interventions related to emergency care for 1 of 1 resident (R49) receiving dialysis services. Findings include R49's diagnoses included end stage renal disease. R49 had a tunneled dialysis catheter in the upper right chest and a shunt (internal access for dialysis treatments) in the left arm. The annual Minimum Data Set (MDS) dated 10/10/12, identified R49 was cognitively intact, and required extensive assistance with transfer, personal hygiene and toileting. The current care plan, revised 1/14/2013, identified R49 received dialysis treatment three times a week, received a renal, diabetic diet, and was on fluid restrictions. The care plan directed staff to check the pulse of shunt on left arm daily. However, the care plan lacked identification R49 had a tunneled dialysis catheter. The care plan lacked special precautions for care of catheter such as no blood draws or flushing of catheter, keep site dry, no tub baths, and covering site when showering. In addition the care plan lacked direction for what procedures to follow if catheter site and/or shunt developed leaking, bleeding, or signs of infection and emergency procedures staff should implement or whom the facility should contact in case of an emergency involving the dialysis shunt (surgically constructed passage) and/or catheter site. During interview on 2/13/13, at 1:29 p.m. nursing assistant (NA)-A stated the dialysis catheter was	F 279	(continued) interventions by the DON at 3/15/13 staff meeting. *PI monitor will be set up by DON to make sure interventions reviewed quarterly & as needed if change in status. Data will be collected by delegated nursing staff & will be reviewed at quarterly PI mtgs. *Policies on care of the dialysis resident will be reviewed. Policies on dialysis emergency care and contact protocols will be developed by DON and approved by medical director. These policies will be reviewed with nursing staff at the 3/15/13 staff meeting. * These policies will also be reviewed with full medical staff at the 3/27/2013 medical staff meeting.	3/15/13	
	<u>F279 Addendum, 3/25/2013</u> <i>There are no other residents currently receiving dialysis.</i> <i>This plan of correction is being implemented for R49 as well as any residents receiving dialysis in the future. Policy and practice changes are applied facility-wide.</i>				

3/25/13
OK
Dha

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F 279	Continued From page 2 to be covered when showering, and shunt sites to be checked for redness or irritation. She did not offer any further information regarding catheter and/or shunt care. During interview on 2/13/13, at 2:47 p.m. registered nurse (RN)- B confirmed the facility utilized temporary nursing agency staff and confirmed R49's current plan of care. RN-B stated emergency dialysis procedures such as bleeding, infection and precautions were not on the care plan and further stated " We do not have it written anywhere. " During interview on 2/13/12, at 2:50 p.m. RN-C confirmed the current care plan and could not provide written instruction for emergency procedures for dialysis catheter or shunt site bleeding. During observation on 2/14/13, at 2:59 p.m. R49 was observed to sit in the television area, in an electric wheel chair and worked on a puzzle. R49 wore a buttoned down shirt, and lifted edge to reveal R49 had an area with white gauze that covered the tunnel catheter site on his chest. R49 pointed to his left arm, and stated the purple colored scars was where he had an internal shunt for dialysis therapy also. During interview on 2/14/13, at 2:59 p.m. R49 stated he required assistance with dialysis access sites, and stated if the dialysis catheter and/or shunt sites were to bleed [R49] would call the nurse and stated "the nurses would do the rest." During interview on 2/15/13, at 11:17 a.m. the director of nursing (DON) confirmed the current	F 279			

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F 279	Continued From page 3 plan of care did not have emergency procedures, precautions for dialysis patients, and further confirmed the facility did not have dialysis policy and procedures for care of dialysis patients.	F 279			

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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, Sanford Canby Medical Center - Sylvan Court 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 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok 3-18-13 RECEIVED MAR 18 2013 MINNESOTA DEPARTMENT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Nancy Salmon

Administrator

3/12/13

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

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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Sanford Canby Medical Center Nursing Home is a 2-story building with full basement. The building was constructed at 4 different times. The original building was constructed in 1941 and was determined to be of Type I(332) construction. In 1964 an addition was constructed and was determined to be of Type I(332) construction. In 1969, an addition was constructed and determined to be of Type I(332) construction. The most recent addition was constructed in 1999 and determined to be of Type II(111) construction. Because the original building and the 3 additions met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the	K 000			

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K 000	Continued From page 2 corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 68 beds and had a census of 60 at time of the survey.	K 000			
K 017 SS=D	The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations, the facility had a penetration in the corridors that is not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient practice could affect the exiting of residents, staff and visitors. In the event of a fire in this space, smoke and fire	K 017	It is the policy of Sanford Sylvan Court to comply with LSC Standards. The ½ inch gap in the cited ceiling tile around the sprinkler head was resolved. All other sprinkler heads were audited for gaps between the head and the ceiling tile, and were found to be in compliance. Director of Plant Operations and Safety Director will monitor ongoing compliance on established and regularly scheduled environmental rounds.	2/25/13	

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K 017	Continued From page 3 could spread into the corridor making it untenable. Findings include: On facility tour between 11:30 AM to 2:30 PM on 2/12/2013, it was observed that the facility has a 1/2 inch gap in a ceiling tile around the sprinkler head located in the corridor outside the sprinkler riser room. This deficient practice was verified by the Maintenance Supervisor (DB). K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=D One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff	K 017			
		K 029	A self-closing mechanism was installed on the door to the freight elevator equipment room. The two penetrations around the electrical conduit cited were sealed. There are self-closing mechanisms on all other affected doors. There are no other unsealed penetrations separating smoke compartments. Director of Plant Operations and Safety Director will monitor ongoing compliance on established and regularly scheduled environmental rounds.		2/27/13

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K 029	Continued From page 4 and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 11:30 AM and 2:30 PM on 02/12/13, observation revealed, that the following deficient conditions were found affecting one of several hazardous storage areas: 1) the door to the freight elevator equipment room on the lower level was not self closing, and 2) there were two penetrations around the electrical conduit located above the door of freight elevator equipment room's door located on the lower level. This deficient practice was verified by the Maintenance Supervisor (DB).	K 029			
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056	The non-functional wires were immediately removed from the fire sprinkler piping. There is no other location in the physical plant where wires or non- system components are attached to fire sprinkling piping. All other components of the Fire Protection System were found to be in compliance.		

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K 056	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). This failure to maintain the sprinkler system in compliance with NFPA 13 (99) and could effect the fire sprinkler system and allow a fire development that would reduce the egress conditions affecting all residents, staff and visitors of the facility. Findings include: On facility tour between 11:30 AM and 2:30 PM on 02/12/13, it was observed that the fire sprinkler piping located in the sprinkler riser room on the lower level of the facility has wires and other non-system components attached to the pipes. This deficient practice was verified by the Maintenance Supervisor (DB).	K 056	Director of Plant Operations and Safety Director will monitor ongoing compliance on established and regularly scheduled environmental rounds.	2/12/13	
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on a complaint received from the Minnesota Department of Health survey team and staff interview, the facility is cooking food that produces grease-laden vapors on a counter top electric grill 6 of 7 days a week basis (not limited), without the proper exhaust hood equipment and	K 069	Breakfast was the only meal where cooking was done in 2 of 4 resident dining rooms. The practice of frying eggs, pancakes, and French toast was discontinued in resident dining rooms on 2/14/13. Menus were immediately revised to reflect the change, and the change was communicated to residents.		

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K 069	Continued From page 6 extinguishing system in accordance with NFPA 101(00), Section 19.3.2.6 and NFPA 96(98) 1-3.1. This deficient practice could affect residents, staff, and visitors. Findings Include: At 3:00 PM on 02/14/13, information was received via email from a Minnesota Department of Health (MDH) Supervisor notifying me that on 02/14/13 at 7:45 AM MDH surveyors witnessed facility staff members cooking eggs in portable griddles in the resident dining rooms located on both the first and second floors. The MDH surveyors also stated that the staff members were cooking eggs using margarine as a release agent and that the margarine was creating grease laden vapors in an area that is not protected by an approved commercial cooking hood equipped with a fire suppression system. After further interviews conducted by the MDH surveyors it was revealed that the facility is cooking eggs, pancakes and French toast 6 out of 7 days a week thus making this deficient practice not limited in nature. This deficient practice was verified by the Facility Administrator (NS).	K 069	No food preparation producing grease-laden vapors will be done in any location in the care center without the proper exhaust hood equipment per LSC Standards. Nutrition Services Manager, Safety Director, and Administrator will monitor ongoing compliance.	2/15/13	