DEPARTMENT OF HEALTH AND HUMAN SERVICES					CENTERS FOR MEDICARE & MEDICAID SERVICES			
					AND TRANSMITTAL	ID: F79W		
	PART I -	TO BE COMPI	LETED BY 1	THE STA	TE SURVEY AGENCY	Facility ID: 00722		
 MEDICARE/MEDICAID PROVID (L1) 245433 	DER NO.	3. NAME AND AE (L3) SYLVAN CC		CILITY		4. TYPE OF ACTION: <u>7</u> (L8)		
2.STATE VENDOR OR MEDICAID	NO.	(L4) 112 ST OLA	-	OUTH		1. Initial 2. Recertification 3. Termination 4. CHOW		
(L2) 490617900		(L5) CANBY, MN	N		(L6) 56220	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE O	FOWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Complaint		
(L9) 6. DATE OF SURVEY 03 /2	19/2014 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP 22 CLIA 14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III		FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	06/30		
11LTC PERIOD OF CERTIFICATIO		10.THE FACILITY	' IS CERTIFIED	AS:		1		
From (a):		X A. In Complian	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements e Based On:		2. Technical Personnel	<u> </u>		
12. Total Facility Beds	68 (L18)	1	ссерtable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	 7. Medical Director NF) 8. Patient Room Size 		
2			1		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	68 (L17)		pliance with Pro- ents and/or Appl		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS			
18 SNF 18/19 SNF	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
68 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Denise Erickson, H	FE NEII	0	3/30/2014	(L19)	Mark Meath	, Enforcement Specialist 05/16/2014 (L20)		
PA	ART II - TO BE	COMPLETED F	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S			
19. DETERMINATION OF ELIGIB	ILITY	20. COM	PLIANCE WIT	H CIVIL	21. 1. Statement of Fina	uncial Solvency (HCFA-2572)		
X 1. Facility is Eligible to	Participate	RIGH	ITS ACT:		 Ownership/Control Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligib	ble							
	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	: (L30)		
OF PARTICIPATION	BEGINNINC	J DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLUNTARY</u>		
02/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Terminatio	on		
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	07-Provider Status Change		
	A. Suspension	n of Admissions:	(L44)			00-Active		
(L27)	B. Rescind Su	spension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)	Posted 07/02/20	014 Co.		
31. RO RECEIPT OF CMS-1539	30	. DETERMINATION		LDATE				
	52	03/24/2014						
	(L32)			(L33)	DETERMINATION APP	ROVAL		

CCN: 24-5433

On March, 20, 2014 a Post Certification Revisit (PCR)was completed. Based on the PCR, we have determined the facility has corrected the deficiencies issued pursuant to the January 30, 2014 standard survey, effective, March 11, 2014. Refer to the CMS 2567b for the results of this visit.

Effective March 11, 2014, the facility is certified for 68 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 24-5433

May 15, 2014

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 11, 2014 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.

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 30, 2014

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

RE: Project Number S5433024

Dear Ms. Salmon:

On February 21, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 2014. 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 March 20, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 30, 2014, effective March 11, 2014 and therefore remedies outlined in our letter to you dated February 21, 2014, 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 related to this letter.

Sincerely,

Mark Meeth

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5433r14.rtf

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 3/20/2014	
Name	e of Facility		Street Address, City, State, Zip Code		
Sì	LVAN COURT		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	()	(5) [Date
0	F0167 483.10(g)(1)	Correction Completed 03/07/2014		F0248 483.15(f)(1)	Correction Completed 03/11/2014		F0252 483.15(h)(1)		Correction Completed _03/11/2014
LSC			LSC			LSC			-
ID Prefix Reg. # LSC	F0279 483.20(d), 483.20(k)(1)	Correction Completed 03/11/2014	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 03/11/2014		F0356 483.30(e)		Correction Completed _03/11/2014
ID Prefix Reg. # LSC	F0371 483.35(i)	Correction Completed 03/11/2014	ID Prefix Reg. # LSC	<u>F0465</u> 483.70(h)	Correction Completed 03/11/2014	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		-	Reg. #			ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Reg. #			
Reviewed By		-	Date:	Signature of Surve	-	1		Date:	
State Agency	, MM/G	A	03/30/201	3	31250	5		03/1*	/2014
Reviewed By CMS RO	Reviewed I	Зу	Date:	Signature of Surve	eyor:			Date:	
Followup to	Survey Completed on: 1/30/2014			-		eficiencies. Was (CMS-2567) Sent	•	YES	NO

Form Approved

OMB NO. 0938-0390

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY		D: F79W Facility ID: 00722	
MEDICARE/MEDICAID PROVIDER NC (L1) 245433 2.STATE VENDOR OR MEDICAID NO. (L2) 490617900 5. EFFECTIVE DATE CHANGE OF OWN		(L5)	COURT LAF AVENUI CANBY, MN	E	(L6) 56220	 TYPE OF ACTION: 1. Initial 3. Termination 5. Validation 7. On-Site Visit 	<u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other	
(L9)	EKSTIII	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	8. Full Survey After Co	omplaint	
6. DATE OF SURVEY 01/30/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2014 (L34)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING 06/30	DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 68 (L37) (L38) 16. STATE SURVEY AGENCY REMARKS	68 (L18) 68 (L17) 19 SNF (L39) 5 (IF APPLICABLE S	Compliance 1. A X B. Not in Com Requirement ICF (L42)	nce With equirements e Based On: Acceptable POC pliance with Program ents and/or Applied V IID (L43)		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B * 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	6. Scope of Servi 7. Medical Direc	tor	
See Attached Remarks								
17. surveyor signature <u>Christina Martinson</u> ,]			03/11/2014	(L19)	(120)			
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partia 2. Facility is not Eligible		20. COM	D BY HCFA RI IPLIANCE WITH C HTS 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	23. LTC AGREEMI BEGINNING		24. LTC AGREEME ENDING DATI		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 22 Direction of the W/Direction	INVOLUN 05-Fail to M	eet Health/Safety	
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIVI A. Suspension of B. Rescind Sus	of Admissions:	(L25) (L44)		02-Dissatisfaction W/ Reimbursemen 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>OTHER</u>	eet Agreement Status Change	
28. TERMINATION DATE:		. INTERMEDIARY/C 03001	(L45) CARRIER NO.		30. REMARKS			
31. RO RECEIPT OF CMS-1539	(L28) 32 (L32)	DETERMINATION (OF APPROVAL DA	(L31) TE (L33)	DETERMINATION APPRO	VAL		

CCN: 24-5433

At the time of the January 30, 2014 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7002 0860 0006 5192 3940

February 21, 2014

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

RE: Project Number S5433024

Dear Ms. Salmon:

On January 30, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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:

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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 Gail Anderson, Unit Supervisor Minnesota Department of Health 1505 Pebble Lake Road, Suite 300 Fergus Falls, Minnesota 56537-3858

Phone: (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 11, 2014, 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

Sylvan Court February 21, 2014 Page 3

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.

Sylvan Court February 21, 2014 Page 4

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 30, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 30, 2014 (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.

Sylvan Court February 21, 2014 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Sincerely,

Mark meath

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

Enclosure

cc: Licensing and Certification File

5433s14.rtf

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245433	B. WING	,	01/3	30/2014
NAME OF P	ROVIDER OR SUPPLIE		1	STREET ADDRESS, CITY, STATE, ZIP CO 112 ST OLAF AVENUE SOUTH CANBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMME	NTS	FO	00		
	as your allegation Department's acc bottom of the first	of correction (POC) will serve of compliance upon the eptance. Your signature at the page of the CMS-2567 form will ation of compliance.				
F 167 SS=C	revisit of your fact validate that subs regulations has b your verification.	n acceptable POC an on-site lity may be conducted to tantial compliance with the een attained in accordance with HT TO SURVEY RESULTS - iSIBLE	F 1		of Sanford	
	the most recent s Federal or State s correction in effect The facility must r examination and	e right to examine the results of urvey of the facility conducted by surveyors and any plan of ct with respect to the facility. make the results available for must post in a place readily idents and must post a notice of		It is the policy and practice Sylvan Court to post Feder survey results and plan of prominently in a place real accessible to residents and survey results have been a on 2 of 3 households. A n	al and State correction dily visible and l visitors. The nd are posted otice is posted	
	This REQUIREM by: Based on intervie facility failed to in and R39) where t located in the fac	ENT is not met as evidenced ew and document review, the form 3 of 3 residents (R57, R38, he state survey results were ility. This practice had the all 66 residents residing in the		on the 3 rd household direct interested to the location of results. A wall-mounted 15"W x 13 holder is labeled "Survey R font size; black letters on v background at a height of above the floor.	of the survey 8"H x 4"D vinyl Results" in 60 vhite	gord
	Findings include:			L. L	VIL OF	Al
BORATORY	DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	3/4	(X6) DATE
ther safegua blowing the ays following	ards provide sufficient date of survey whethe g the date these docur	th an asterisk (*) denotes a deficiency where the patients. (See instruction ror not a plan of correction is provided. In the next are made available to the facility.	ns.) Excep For nursing	t for nursing homes, the findings stated a homes, the above findings and plans of ies are cited, an approved plan of correct	above are disclosa correction are dis- tion is requisite to	ible 90 days closable 14
rogram parti				RECEIV	/ED	t Page 1 of 21

MN Dept of Health Fergus Falls

PRINTED: 02/21/2014

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
	245433	B. WING	0	1/30/2014
		1'	TREET ADDRESS, CITY, STATE, ZIP CODE 12 ST OLAF AVENUE SOUTH	
(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
During interview on stated she was a m and routinely attend that she had no ide results were locate was not aware she results. The annual dated 11/14/13, ind intact.	1/30/14, at 9:54 a.m., R57 nember of the resident council ded meetings. She reported a where the state survey d in the facility and stated she could review the survey Minimum Data Set (MDS) icated R57 was cognitively	F 167	Survey Results	
reported that she d survey results were quarterly MDS date	id not know where the state located in the facility. The d 1/2/14, indicated R38 had		between resident rooms and the dining,	
stated she was not survey results were admission MDS da	aware of where the state located in the facility. The ted 10/23/13, indicated R39		is communicated at the time of admission in a booklet, "Your Rights Under the Combined Federal and	d
community life coor held the resident co for the past nine mo she had not review to review the state confirmed the resid	dinator (CLC) reported she buncil meetings every month onths. The CLC confirmed ed with the residents their right survey results, and also ents had not been told where	Ĩ	Residents 57, 38, and 39 were shown where the survey results are posted.	11
	(EACH DEFICIENCY REGULATORY OR L Continued From participation During interview on stated she was a m and routinely attend that she had no ide results were located was not aware she results. The annual dated 11/14/13, ind intact. During interview on reported that she d survey results were quarterly MDS dates moderate cognitive During interview on stated she was not survey results were admission MDS dates was cognitively inta During interview on community life coor held the resident co for the past nine mo she had not review to review the states confirmed the resident	DF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 245433 PROVIDER OR SUPPLIER COURT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 During interview on 1/30/14, at 9:54 a.m., R57 stated she was a member of the resident council and routinely attended meetings. She reported that she had no idea where the state survey results were located in the facility and stated she was not aware she could review the survey results. The annual Minimum Data Set (MDS) dated 11/14/13, indicated R57 was cognitively	DF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 245433 B. WING PROVIDER OR SUPPLIER S COURT 11 COURT 10 PREVIDER OR SUPPLIER S (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 1 F 167 During interview on 1/30/14, at 9:54 a.m., R57 stated she was a member of the resident council and routinely attended meetings. She reported that she had no idea where the state survey results were located in the facility and stated she was not aware she could review the survey results. The annual Minimum Data Set (MDS) dated 11/14/13, indicated R57 was cognitively intact. During interview on 1/30/14, at 11:30 a.m., R38 reported that she did not know where the state survey results were located in the facility. The quarterly MDS dated 10/23/13, indicated R38 had moderate cognitive impairment. During interview on 1/30/14, at 11:27 a.m., R39 stated she was not aware of where the state survey results were located in the facility. The admission MDS dated 10/23/13, indicated R39 was cognitively intact. During interview on 1/30/14, at 11:30 a.m., the community life coordinator (CLC) reported she held the resident council meetings every month for the past nine months. The CLC confirmed she had not reviewed with the residents their right to review the state survey results, and also confirmed the residents had not been told where	PF CORRECTION IDENTIFICATION NUMBER A BUILDING 0 245433 B. WING 0 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 112 ST OLAF AVENUE SOUTH COURT SUMMARY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER PLANCEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP CODE (BACH DEFICIENCY MUST GE PRECEDED BY FULL STREET ADDRESS, CITY, STATE, ZIP CODE 112 ST OLAF AVENUE SOUTH (BACH DEFICIENCY MUST GE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYMON INFORMATION) PREFIX CARDES AVENUE SOUTH Continued From page 1 IDENTIFY MIST ARE AND THE APPROPRIATE DEFICIENCY IDENTIFY AND THE APPROPRIATE DEFICIENCY CORSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 1 IDENTIFY AND THE APPROPRIATE DEFICIENCY IDENTIFY AND THE APPROPRIATE DEFICIENCY Continued From page 1 IDENTIFY AND THE APPROPRIATE DEFICIENCY IDENTIFY AND THE APPROPRIATE DEFICIENCY Presults were located in the facility and stated she was not aware she could review the state survey results were located in the facility. The quartery MDS dated 11/14/11, indicated R38 had moderate cognitive impairment. The vinyl holder is located in a corridor between resident rooms and the dining/ During interview on 1/30/14, at 11:27 a.m., R39 stated she was not aware of where the state survey results were located in the facility. The quarticy MDS dated 11/21/1, indicated R3

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		AND HUMAN SERVICES				FORM	02/21/2014 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		E SURVEY PLETED
		245433	B. WING			01/;	30/2014
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SYLVAN	COURT				2 ST OLAF AVENUE SOUTH ANBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 167	right to review state one year ago, but h residents since the residents or reside resident council me year ago, would no review and the loca AD confirmed the r the setting to review included the right to results and their loc not been done.	D) stated she had reviewed the e survey results greater than had not discussed this with n. She confirmed any new nts that had not attended the beeting held greater than one it be made aware of the right to ation of the survey results. The resident council meeting was w resident rights, which o review the state survey cation and confirmed this had	F	167	Medical Record form #768.86, Sy Court Care Conference Review, h revised to include a reminder to e resident of the location of posted results. This form is completed q The revised form will assure ongo compliance. RN Care Coordinators who condu quarterly Care Conferences will c the form.	as been each I survey uarterly bing ict the	
F 248 SS=D	facility. 483.15(f)(1) ACTIV INTERESTS/NEED The facility must proof activities design the comprehensive the physical, menta of each resident. This REQUIREME by: Based on observa- review the facility f services in a mann	sted, but not provided by the	F	248	It is the policy of Sylvan Court provide leisure activities to me needs of each resident. Resident #27's activity care pla indicates that a minimum of tw to-one activities be conducted Resident #24 every week. Elev to-one activities were docume the month of January 2014. A	eet the an wo one- with ven one nted fo	

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00722

		AND HUMAN SERVICES				FORM	02/21/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	E SURVEY IPLETED
		245433	B. WING	i		01/	30/2014
NAME OF F	ROVIDER OR SUPPLIER	L	4	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SYLVAN	COURT			1	2 ST OLAF AVENUE SOUTH ANBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 248	Continued From pa	ge 3	F:	248			
	for activities.				two one-to-ones were conduc	ted eve	rv
					full week of the month. Two t		1
Findings include:					during the month, the one-to-		
					were 5 days apart. One-to-on		e
		imum Data Set (MDS) dated			documented on 1/24/14 and a	again or	1
		severe cognitive impairment luding dementia, Parkinson's			1/29/14. The one-to-ones cor	rrelated	
WOARD OF ALL IN		ssion. The MDS indicated			with Resident #27's document	ted	
	R27 relied on staff for locomotion, and extensive				interests.		
		or ambulation. The annual , failed to identify any activity			Resident #27's Daily Activity A	ttendar	ice
	preferences for R27.			a for a subscription	Record indicates that Residen		
	D07's sere plan def		gane a se a based in some	participated in between 1 and	6 grou	p	
		ted 4/25/12, indicated an specially a Vikings fan, easy			activities 27 of the 31 days in .	January	•
!	listening music, cou	untry music, old movies, piano, ch, playing catch, and talking			Because of Resident #27's sev	ere	
	to stuffed animals.	on, playing baton, and taking			cognitive impairment, he ben	efits fro	m
	An undeted Activity	Droferance Guide identified			basic, concrete physical intera	iction, li	ke
		Preference Guide identified ing sports, soft music, country			ball toss which he does do. Sr	nall gro	up
	music, old movies,	piano, bird watching, church,			activities on the household w	nere #2	7
	playing catch, and a busy.	activities that kept his hands			resides are more appropriate	to his	
	budy.			94 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	functional level. Resident #27	"s passi	ve
	D07 was abaaried	in the Willow Lane dining			presence at a group activity o	ut of his	
		t 9:39 a.m. A News and			usual environment aimed at n	nore	
	Movies activity was	in process. R27 was asleep			cognitively intact residents, su	ich as a	
		el chair and did not participate. In to wake him during the			church service or Bible study,		
	activity.				distressing to Resident #27 as		_
					evidenced by loud guttural no		d
	dining room at a tak	to be in the Willow Lane ble on 1/28/14 at 2:00 p.m. e dining room while there was			ataxic movements of extremit	ies.	

					PRINTED: 02/21/2014 FORM APPROVED OMB NO: 0938-0391
STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245433	B. WING _		01/30/2014
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	
SYLVAN	COURT			112 ST OLAF AVENUE SOUTH CANBY, MN 56220	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 248	Continued From pa	age 4	F 24	48	
	R27 was observed at 10:45 a.m. A St activity program wa facility. R27 was observed the table in the Wil 1/29/14, at 1:52 p.1 elsewhere in the fa When interviewed nursing assistant (assisted to any act reviewed documer and verified the las in was documenter of watching televis the NA's or activity residents to activity participation. On 1/30/14 at 9:20 conducting Standin the chapel of the fa was observed sea	on 1/29/14, at 1:55 p.m. NA)-A stated R27 had not been ivities on 1/29/14. NA-A itation of activity participation at activity R27 had participated d as a 1:1 (one on one) activity ion on 1/24/14. NA-A stated staff were responsible to get		On days that staff sees the #27 is more alert and resp usual, group activities, such music, may be attempted Resident #27's activity can reviewed. When appropri- assist Resident #27 to atter group activities. Religious tapes may be offered to F Staff will document more one's and group activities above the care plan minin Resident #27 participates All of the care plans for re- same household as Reside reviewed, found be appro- were being carried out as Care plans for residents w dementia diagnosis, or re- history of non-participatic on other households at Sy were reviewed by the Cor	ponsive than ch as live when offered. re plan was riate, staff will end on-site s music and tesident #24. of the one-to- over and num that in. esidents in the ent #27 were opriate, and care planned. vith a sidents with a on in activities, vivan Court
	seated at dining ro activity was occurr	a.m. R27 was observed om table by himself while an ing elsewhere in the facility. (RN)-A was interviewed about		Coordinator and respectiv Coordinators and found to acceptable. The importar documenting leisure activ	o be nce of

If continuation sheet Page 5 of 21

		AND HUMAN SERVICES			FORM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245433	B. WING		01/30/2014
NAME OF F SYLVAN (X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
F 248	stated, "He should been able to partici R27 could stand an further stated it was activity because he toileted prior to goin "[R27] needs to be have taken him." When interviewed of community living di should be assisting encouraging him to R27 enjoyed music participate in the ex- stated R27 should the past three days not been. Even though R27 h enjoying, and being activity programs th not been assisted t	ge 5 articipating in activities. RN-A be in the activity as he has pate in the past." RN-A stated id walk with assist. RN-A s too late to take R27 to the needed to be checked and ng to the activity. RN-A stated, clean if he goes. We should on 1/30/14 at 10:05 a.m. , the rector (CLD)-B, stated staff R27 to activities and participate. CLD-B stated and would be able to kercise programs. CLD-B have been taken to activities and did not know why he had had been assessed as a capable of participating in he facility had available, he had o them, or encouraged to 14 through 1/30/14.	F 24	DEFICIENCY) Participation was communic staff in writing. Two Performance Improvem random audits were and are conducted monthly to assure compliance with activity care the quality of leisure activitie Individual one-to-ones, and 2 Household leisure pursuit gro- staff are informed monthly of results of the audits and area improvement. Activity care plans are review quarterly by the Care Confer and updated as indicated by Community Life Coordinator	ent being e e plans and es; 1) 2) oups. All of the as for ved ence Team the
F 252 SS=E	facility. 483.15(h)(1) SAFE/CLEAN/COM ENVIRONMENT The facility must pr comfortable and ho	sted, but not provided by the //FORTABLE/HOMELIKE ovide a safe, clean, melike environment, allowing his or her personal belongings	F 25	Sylvan Court provides a hom environment in four dining r located on the three facility Only sixteen residents live or Household. 23 residents live	ooms households. n Willow

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		AND HUMAN SERVICES				FORM	02/21/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245433	B. WING	i		01/	30/2014
NAME OF I	PROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SYLVAN	COURT				12 ST OLAF AVENUE SOUTH ANBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 252	Continued From pa	-	F2	252			
ĺ	to the extent possib	le.			and 29 residents live on Oak. W	/hile	
					Maple and Oak were construct		e
		NT is not met as evidenced			1960's, Willow Household was		
	by: Based on observat	ion, interview, and document			constructed in 1999; the rooms	in	
		ailed to provide a home like			Willow are larger and ADA com	pliant	
		or 12 of 12 residents(R45, , R27, R15, R47, R56, R23,			making it more manageable for		
	R62, and R50) who	ate in the Willow dining room,			residents requiring the use of		
	trays.	ere served on plastic food			mechanical lifts or physical assi		o
					staff members in the toilet room		
	Findings Include:				addition, Willow has no through		
	· · · · · · · · · · · · · · · · · · ·	đ			of laundry carts, meal carts, or carts; no overhead paging, and		
	During dining obser	vation in the Willow dining			direct exit to the outdoors; tho		
	room, on 1/28/14,	at 12:00 p.m. R45, R4, R32,			features, along with the smaller		
		5, R47, R56, R23, R62 and the tables with food items on			population, make Willow a desi		
	gray plastic trays si	tting in front of them. During			household for residents who m		
		esidents on the Oak and erved meals off of a steam			bothered by excess stimuli. The	ose	
	table, not off of prep				residents often have a dementi	а	
	••••	·			diagnosis and may find making	choices	
	During dining room	observation in the Willow			difficult or frustrating. Consequent	ently,	
	dining room, on 1/2	9/14, at 8:00 a.m. R45, R4,			Willow Household has been be		
		5, R47, R56, R23, R33, R62 ng at tables with food items on			served by decreasing the activit	-	
	eleven gray plastic	trays and one black speckled			demand for choices at mealtim	e.	
		able in front of them at they were eating. During this			Any Willow resident desiring to	eat in	
	meal service, reside	ents on the Oak and Maple			one of the other dining rooms i		
	units were served n off of prepared trays	neals off of a steam table, not s.			that option. Any Willow reside	nt who	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			U	<u>MB NO.</u>	0930-0391
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245433	B. WING		· · · · · · · · · · · · · · · · · · ·	01/:	30/2014
NAME OF	PROVIDER OR SUPPLIER	Language		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
SYLVAN	COURT				ST OLAF AVENUE SOUTH		
				CA	NBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 252	During dining room 12:00 p.m. R45, R4 R56, R23, R33, R6 table with food item on the table in front they were eating. It residents on the Oa	ige 7 observation on 1/30/14, at R R32, R34, R27, R15, R47, 2 and R50, were sitting at the is on gray plastic trays sitting of them at lunch time while During this meal service, ak and Maple units were a steam table, not off of	F	252	would prefer making meal choi the steam tables is given that o Dining and nutrition are review least quarterly with each reside and/or family member who giv at the Quarterly Care Conferen Plates, glasses, cups, silverware	option. ved at ent ves input ce.	C
	nutritional foods ma residents in the Wil their meals off a fo They started this ar because the extra s the residents anxio re-addressed this is even though this wa of doing things, and changed. The NFI	on 1/30/14, at 8:40 a.m. the anager (NFM) stated only low dining room are served od cart, on prepared trays. oproximately three years ago staff and equipment had made us. They had not ssue in the past few years, as more of an institutional way I the resident population had M agreed meals were not home like environment for			other utensils are removed from tray and placed directly on the placemat for the residents in W Trays are also removed before meal to residents who choose to their rooms. When residents h requested that their meal rema tray, their request is honored a planned.	m the table or /illow. serving to eat in ave ain on a and care	a
	director of nursing (Willow dining room the steam table a fe residents had not b A facility policy entii dated 5/2011, include meals served were procedure identified were provided by a	on 1/30/14, at 9:03 a.m. the (DON) stated residents in the did not want food served from ew years ago. Current een consulted. the Patient Meal Service ded a purpose of ensuring attractively presented. The d Senior Haven meal serves steam table going to 1st and ee meals and included With			Policy #803.401, Patient Meal S has been updated. The Willow RN Care Coordinato addressed meal site and delive preference with all current resi and will address it at each resic quarterly care conference.	or has ry dents,	3/11/14

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Event ID: F79W11

Facility ID: 00722

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					×	110 110	0920-0291	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		245433	B. WING	i		01/	30/2014	
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	DE		
	COUDT			1	12 ST OLAF AVENUE SOUTH			
SYLVAN	COURT			c	ANBY, MN 56220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 252 F 279 SS=D	residents being abl like. The Unit resid steam table at the r policy did not addre	e to choose what they would lents were served from the noon and supper meal. The ess serving residents in the differently, on plastic trays. ((1) DEVELOP		252 279				
22=D	A facility must use to to develop, review a comprehensive pla The facility must de plan for each reside objectives and time medical, nursing, a needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident §483.10, including funder §483.10(b)(4) This REQUIREMENT by: Based on interview facility failed to dev plan to identify diab	the results of the assessment and revise the resident's in of care. Evelop a comprehensive care ent that includes measurable tables to meet a resident's ind mental and psychosocial tified in the comprehensive t describe the services that are ttain or maintain the resident's physical, mental, and reing as required under ervices that would otherwise 3483.25 but are not provided is exercise of rights under the right to refuse treatment			 The care plan for R24 has been by RN Care Coordinator and DC include addressing diagnosis of Mellitus, goals for this problem interventions to carry out orde cares. The care plans for all residents Diabetes will be reviewed to as have Diabetes addressed. Policies and procedures for car have been reviewed and updat include a new checklist to asce active diagnoses are addressed resident's care plan. Nursing st trained on this checklist via a "I Sign" instructional sheet. A Performance Improvement in will be set up by the DON to au the checklist is completed upor admission, with a hospital returned on the should be a solution. 	DN to f Diabet n, and rs and with ssure all re planni red to rtain all l on eacl aff will k Read an ndicator ndit that	ng n d	

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Facility ID: 00722

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		AND HUMAN SERVICES				FORM	02/21/2014 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE SURVEY COMPLETED		
		245433	B. WING	i		01/:	30/2014	
NAME OF I	PROVIDER OR SUPPLIER	n davlandarina in david i david		s	STREET ADDRESS, CITY, STATE, ZIP CODE			
SYLVAN	COURT							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 279	Continued From pa	ge 9	F	279				
	Findings include:							
	Findings include:				with significant change in state			
	D04le querterly Min	imum Data Sat (MDS) datad			applicable. Audit will be condu			
	R24's quarterly Minimum Data Set (MDS) dated 12/17/13, included severe cognitive impairment				monthly by delegated nursing		d	
	and included a diagnosis of diabetes mellitus.				findings will be reviewed quart	erly at		
					QAPI meetings.		3/11/14	
	included to check b	ler report dated 1/29/14, lood sugar Monday through alternating times as well as					J) 11) 17	
	mood, physical care hospice care. The	t updated 1/6/14, addressed e, activities, comfort and care plan failed to identify the s and did not give directions iabetes.						
	registered nurse (R have a care plan th diabetes, then state have one, we shoul monitoring for hypo hyperglycemia [high	1/29/14, at 2:05 p.m., N)-B confirmed R24 did not at addressed the problem of ed, "I can't believe we don't Id have one in there with glycemia [low blood sugar] or n blood sugar], accuchecks s], we normally do complete						
	director of nursing (did not develop a co R24. The DON sta missed, she has be	1/30/14, at 11:56 a.m. the (DON) confirmed the facility omprehensive care plan for ted, "It should not have been en here a long time, at least N reported that each						

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245433	B. WING			01/:	30/2014
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
SYLVAN	COURT				12 ST OLAF AVENUE SOUTH CANBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	і IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 279 F 282 SS=D	disease processes The facility's Asses Interdisciplinary Pla indicated the facility the care needed fo 483.20(k)(3)(ii) SEF PERSONS/PER C/ The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observa review, the facility f directed by the care (R27) reviewed for Findings include: The care plan date interests in sports, listening music, cou bird watching, chur to stuffed animals.	a should address active , medications and treatments. sment of Residents and an of Care Policy dated 11/10, y would assess and determine r each resident. RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in ach resident's written plan of NT is not met as evidenced tion, interview, and document ailed to provide activities as a plan for 1 of 3 residents activities. d 4/25/12, indicated R27 had especially a Vikings fan, easy untry music, old movies, piano, ch, playing catch, and talking		279	It is the policy of Sylvan Court is provide leisure activities to me needs of each resident. Resident #27's activity care plat indicates that a minimum of tw to-one activities be conducted Resident #24 every week. Eleve to-one activities were docume the month of January 2014. At two one-to-ones were conduct full week of the month. Two to during the month, the one-to-one documented on 1/24/14 and a 1/29/14. The one-to-ones corr with Resident #27's document interests. Resident #27's Daily Activity At Record indicates that Resident participated in between 1 and activities 27 of the 31 days in J Because of Resident #27's seve	eet the an vo one- with ven one- nted for t least ted ever imes ones e's were gain on related related ed ttendand ed ttendand anuary. ere	çe
	R27 was observed in the Willow Lane dining room on 1/28/14, at 9:39 a.m. A News and Movies activity was in process. R27 was asleep in his reclining wheel chair and did not participate Staff did not attempt to wake him during the				cognitive impairment, he bene basic, concrete physical intera ball toss which he does do. Sm	ction, lik	e

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00722

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		AND HUMAN SERVICES				FORM	02/21/2014 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC			E SURVEY PLETED			
	5	245433	B. WING	i		01/30/2014			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
SYLVAN	COURT		112 ST OLAF AVENUE SOUTH CANBY, MN 56220						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 282	Continued From pa activity.	ge 11	F 2	282					
					activities on the household whe	ere #27			
	P27 was observed	to be in the Willow Lane			resides are more appropriate t				
		ble on 1/28/14 at 2:00 p.m.			functional level. Resident #27'		e		
		e dining room while there was			presence at a group activity ou	1			
	a Bible Study activi	ty going on in a different room.		:	usual environment aimed at m				
	D07 was share a	to be lying in bod on $1/20/11$			cognitively intact residents, suc church service or Bible study, c				
		to be lying in bed on 1/29/14, anding Strong (exercise)			distressing to Resident #27 as	••			
	activity program wa	as occurring elsewhere in the			evidenced by loud guttural noi	ses and			
	facility.				ataxic movements of extremitie				
	D27 was sheered	alconing in his wheel shair at			On days that staff sees that Res	sident			
		sleeping in his wheel chair at ow Lane dining room on			#27 is more alert and responsiv				
		n. An activity was going on			usual, group activities, such as	live			
	elsewhere in the fac	Cinty.			music, may be attempted wher	n offere	d.		
	When interviewed of	on 1/29/14, at 1:55 p.m.			Resident #27's activity care pla				
	nursing assistant (N	NA)-A stated R27 had not been			reviewed. When appropriate,		I		
		vities on 1/29/14. NA-A tation of activity participation			assist Resident #27 to attend o				
	and verified the last	t activity R27 had participated			group activities. Religious mus				
		l as a 1:1 (one on one) activity on on 1/24/14. NA-A stated			tapes may be offered to Reside Staff will document more of the				
	the NA's or activity	staff were responsible to get			one's and group activities over		,		
	residents to activitie participation.	es and encourage			above the care plan minimum t				
	paracipation				Resident #27 participates in.				
		a.m. activity staff were			All of the care plans for residen	ts in the	9		
		g Strong exercise program in cility. During the activity R27			same household as Resident #2	7 were			
	was observed seate	ed in the Willow Lane dining			reviewed, found be appropriate				
	room at table with c table without any ac	other residents around the ctivity.			were being carried out as care	planned	l. –		

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<u> </u>	<u>AS FOR MEDICARE</u>					ID NO.	0930-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		E CONSTRUCTION (>		E SURVEY PLETED
		245433	B. WING	i		01/3	30/2014
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD				
SYLVAN	COURT			112 ST OLAF AVENUE SOUTH CANBY, MN 56220			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From pa	ige 12	F:	282			
	On 1/30/14 at 9:35 seated at dining rod activity was occurri Registered nurse (I why R27 was not p stated, "He should been able to partici R27 could stand ar further stated it was activity because he toileted prior to goin "[R27] needs to be have taken him." When interviewed of community living di should be assisting encouraging him to R27 enjoyed music participate in the ex confirmed R27's ca have been taken to	a.m. R27 was observed om table by himself while an ng elsewhere in the facility. RN)-A was interviewed about articipating in activities. RN-A be in the activity as he has pate in the past." RN-A stated ind walk with assist. RN-A s too late to take R27 to the eneeded to be checked and ing to the activity. RN-A stated, clean if he goes. We should on 1/30/14 at 10:05 a.m. , the rector (CLD)-B, stated staff R27 to activities and participate. CLD-B stated and would be able to kercise programs. CLD-B ire plan and stated R27 should activities the past three days why he had not been.			Care plans for residents with a dementia diagnosis, or residents history of non-participation in ac on other households at Sylvan Co were reviewed by the Communit Coordinator and respective RN C Coordinators and found to be acceptable. The importance of documenting leisure activity participation was communicated staff in writing. Two Performance Improvement random audits were and are bein conducted monthly to assure compliance with activity care pla the quality of leisure activities; 1 Individual one-to-ones, and 2) Household leisure pursuit groups staff are informed monthly of the	ctivities ourt ty Life Care d to all ng ans anc .) s. All	s,
F 356 SS=C	facility. 483.30(e) POSTED INFORMATION The facility must po a daily basis: o Facility name. o The current date.	sted, but not provided by the NURSE STAFFING ost the following information on	F	356	results of the audits and areas fo improvement. Activity care plans are reviewed quarterly by the Care Conference and updated as indicated by the Community Life Coordinator.	or e Tean	ו 3/11/14
	a daily basis: o Facility name. o The current date.	est the following information on and the actual hours worked			•		

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<u> </u>	RS FUR MEDICARE	: & MEDICAID SERVICES			U		0930-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245433	B. WING	÷		01/:	30/2014
NAME OF	PROVIDER OR SUPPLIER		•	1'	TREET ADDRESS, CITY, STATE, ZIP CODE 12 ST OLAF AVENUE SOUTH ANBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 356	by the following cat unlicensed nursing resident care per st - Registered nu - Licensed prace vocational nurses (- Certified nurse o Resident census. The facility must po specified above on of each shift. Data o Clear and readab o In a prominent pla residents and visito The facility must, u make nurse staffing for review at a cost standard. The facility must mas staffing data for a mas required by State lat This REQUIREMEN by: Based on observat review, the facility f staffing information the actual hours wo nursing staff. This 66 current residents	egories of licensed and staff directly responsible for hift: rses. tical nurses or licensed as defined under State law). e aides. ost the nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to	F	356	It has been and is Sylvan Court's p to post the daily nurse staffing leve each shift and by each category of nursing staff. Daily census and shift start times a shift duration have been added to posting. It remains the Staffing Coordinator responsibility to post the initial information, the charge nurse to u the document if/when staffing or of changes, and the night nurse to sw the posting to the current day. The night nurse will route the past posting back to the Staffing Coordi to close the loop. The Staffing Coordinator will verify census and staffing changes were r and report to the DON.	els by ind the r's pdate census vitch day's nator	3/11/14

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	<u>RS FUR MEDICARE</u>						. 0930-039
	T OF DEFICIENCIES OF CORRECTION				e survey Ipleted		
		245433	B. WING			01/	30/2014
NAME OF	PROVIDER OR SUPPLIER	L		11	TREET ADDRESS, CITY, STATE, ZIP CODE 12 ST OLAF AVENUE SOUTH CANBY, MN 56220	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 356	Continued From pa	age 14	F	356			
	required posting of observed on a wall nurses station. The the resident census by each category of and 1/29/14, again failed to include the	ur on 1/27/14, at 6:10 p.m. the nurse staffing information was directly across from the e posting did not include s, or the actual hours worked of nursing staff. On 1/28/14 the nurse staffing information e resident census or actual ach category of nursing staff.					
•	registered nurse (F coordinator is resp information daily. R did not edit or chan	n 1/29/14, at 7:30 a.m. RN)-B reported the staffing onsible to post the nurse staff RN-B stated the nursing staff age the information on the form oordinator completed the form.					
	staffing coordinator responsible for the posting. The SC re posting behind the each day, and state to switch the postin SC confirmed that resident census an hours worked for re	a 1/29/14, at 8:39 a.m. the (SC) stated he was only development of the nurse staff eported he put the next days current posting by 4:00 p.m. ed nursing staff were supposed og when the date changes. The the posting did not include the d did not identify the actual egistered nurses, licensed and certified nurse aides.					
	director of nursing shift nurse's respor staff posting to the confirmed the posti	1/29/14, at 8:41 a.m. the (DON) stated it was the night nsibility to switch the nurse current date. The DON ing lacked the resident census orked in each category, then					

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		& MEDICAID SERVICES			OMB NO. 0938-039 (X3) DATE SURVEY		
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SU ND PLAN OF CORRECTION IDENTIFICATIO					(X3) DATI COM	E SURVEY PLETED
		245433	B. WING			01/3	30/2014
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SYLVAN	COURT			112 CA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 356	· ·	must have gotten changed on	F 3	56			
F 371 SS=E			F 3	571	It is the policy of Sylvan Cour food in a sanitary manner. The staff member who picke menu slip from the floor was identified. All nursing and di have been reminded that ite have had contact with the flo discarded or sanitized.	d up the not etary stafi ms which	
	by: Based on observative review, the facility f sanitary manner to borne illness for 6 of R29, R2, and R65) Maple and Oak din Findings include: During observation 1/28/14, at 11:39 a. and filled out their r At 11:41 a.m. a res	NT is not met as evidenced tion, interview, and document ailed to serve food in a prevent the spread of food of 54 residents (R79, R20, who were served food in the ing rooms			The NFS Manager talked with DA-B about the observed bre protocol. DA-A and DA-B ind they understood the error ar correct procedure was. Dietary staff were given instr 2/19/14 on hand hygiene, ide clean and dirty surfaces, and specific scenarios (including to by the NFS Manager and Sup Several serving processes we streamlined to enhance com	ach of icated tha id what th uction on entifying were give hose cite ervisor. re	it ie

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Event ID: F79W11

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245433	B. WING		·	01/	30/2014
NAME OF	r		1	11	TREET ADDRESS, CITY, STATE, ZIP CODE 12 ST OLAF AVENUE SOUTH ANBY, MN 56220		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	the menu slip up from menu slip with the of a silver cart next to At 12:04 p.m., dieta type gloves on both going through the m touching each piece hands. At 12:09 p.m., weat contaminated by th into a bag of deli ha ham slice in half an DA-B handled the se each plate served w At 12:12 p.m., weat DA-B handled anot condiments from a table. DA-B immed bread from a plastic sandwich using the did not change her At 12:13 p.m., weat DA-B handled anot plate she prepared. deli ham two times then reached into th two pieces of bread sandwich. Wearing handled another me	e floor. A staff member picked om the floor and put the dirty other completed menu slips on	FS	371	 tongs will be used to pick usuch as sandwich meat instatouching the item directly, all items needed from the stable drawer will be removaserving begins, the dishing process has been engineered so that the servanot touch the menus. The Infection Control policy for Dietary department and the IC regarding hand hygiene have bereviewed and revised as indicated and revised as indicated times per year by the NFS Mar Supervisor. The NFS Manager and Supervisor of being served on the households will be implement reported on at QAPI and Dietated at least questions of the server of the	ead of iteam ed befor en rer will r the policy been ited. cific to two hager an sor have food ds. An he ed and ry Staff	d

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>IMB NO.</u>	0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		245433	B. WING		·	01/	30/2014
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SYLVAN	COURT				12 ST OLAF AVENUE SOUTH CANBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	Continued From par hands, and proceed sandwich. DA-A pro- gloved hand over the sandwich with the of The ham sandwich gloved hands, were and R2. During interview of confirmed she wore during the entire me handled each resid preparing each mean handled ready to ear and bread, with the DA-B then stated, " During interview on dietary manager (D menu slips dirty, be and others have too staff should change	age 17 ded to assemble the ham beeeded to place one dirty ne entire sandwich and cut the other dirty gloved hand. es made by DA-B, using dirty e served to R79, R20, R29, 1/28/14, at 12:31 p.m., DA-B e the same pair of gloves eal service, and verified she ent menu slip between al. DA-B confirmed she had at foods, including deli ham e same contaminated gloves. I serve like that all the time." 1/29/14, at 12:07 p.m., the be they are not a food item uched them. The DM stated e their gloves every time they red item and staff have been	,	371			
		,					

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION			E SURVEY PLETED
		245433	B. WING _				01/:	30/2014
NAME OF F	PROVIDER OR SUPPLIER	aarwahaanna a			ET ADDRESS, CITY, STATE, ZIP CODI	Ξ		
SYLVAN	COURT		112 ST OLAF AVENUE SOUTH CANBY, MN 56220					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 18	F 37	71				
	Oak dining room or was serving resider donned vinyl-type g the bottom drawer or retrieved an individu for a resident meal. out and removed a buttered the toast, I hands, then cut the	of the breakfast meal in the 1/29/14, at 8:05 a.m. DA-A ht breakfast meals. DA-A loves on both hands, opened on the steam table and ual pack of breakfast cereal DA-A immediately reached slice of toast from the toaster, nolding it with the same gloved toast and placed it on a plate t items and served the meal to						
	of bread in the toas from the cart, picke juice, and poured ju the same gloves, D plastic bag of biscu table, and placed th Wearing the same of the steam table t toast from the toast	donned gloves, placed a slice ter, removed a drinking glass d up a container of apple lice into the glass. Wearing A-A proceeded to reach into a its on the top of the steam be biscuit on a resident plate. gloves, DA-A opened drawers hen proceeded to remove the er, placed the toast on a plate t items and served the meal to						
	serve resident mea gloves became con be changed. DA-A	stated it was usual practice to ls with gloves, and if the taminated, the gloves were to confirmed the above s and indicated she did not				<u>,</u>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245433 B. WING 01/30/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **112 ST OLAF AVENUE SOUTH** SYLVAN COURT CANBY, MN 56220 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 371 Continued From page 19 F 371 realize cross contamination had happened. The facility's Dietary Infection Control policy dated 2/09, directed staff to use proper food handling techniques to control the growth of bacterial infections. F 465 483.70(h) F 465 SAFE/FUNCTIONAL/SANITARY/COMFORTABL SS=C E ENVIRON It is the practice of Sylvan Court to The facility must provide a safe, functional, maintain a clean and sanitary kitchen. sanitary, and comfortable environment for residents, staff and the public. The stove and the fryer have generally been positioned side-by-side, flush with This REQUIREMENT is not met as evidenced each other. Grease spatters were by: contained because there was no space Based on observation, interview and document between the two appliances. review the facility failed to maintain clean, sanitary equipment in the main kitchen of the facility, which had the potential to affect 66 of 66 These two appliances were moved residents. apart at some point (for cleaning or service) and not moved back together. Findings Include: The grease on the sides of the oven and During tour of the kitchen with the Nutritional fryer was cleaned off. The floor Food Manager (NFM), on 1/29/14, at 2:40 p.m. a between the two appliances was silver colored stove was located between a deep fryer and a conventional oven. The stove had a cleaned. The two appliances were large amount of dust covered grease spilled down moved flush with each other. both side panels, covering the majority of the side panels. The NFM confirmed the large amount of Shift Position Task Lists have been grease build up on both sides of the stove. She reviewed and updated. Oven cleaning stated different cleaning duties are assigned to dietary staff, however, cleaning the sides of the has been assigned to Shift Position #C2. stove was not assigned to anyone.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

		AND HUMAN SERVICES				FORM	02/21/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245433	B. WING			01/:	30/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SYLVAN	COURT				12 ST OLAF AVENUE SOUTH ANBY, MN 56220		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	Continued From pa	ige 20	F	465			
					Cleaning for all areas, appliance	s.	
		sts were provided for each			equipment, and surfaces have b		
	listed on each list, I	sition, Cleaning Jobs were nowever, routine cleaning of		Ì	assigned to a specific Shift Posit	1	
	the stove was not in	ncluded on the cleaning lists.			Weekly audits of all kitchen area	as,	
					appliances, equipment, and sur	faces	
					will be conducted by an individu	ial othe	er j
					than the person assigned to clea	an that	
					particular area to assure that cle	eaning	S ·
					being done as frequently and		
					thoroughly as directed.		
					The NFS Supervisor or Manager		
					make weekly audit assignments review them for variances. Auc		
					results will be a standing agenda		
					for Dietary department meeting		
					written communications, and Q		
							3/11/14
							Ĩ
						-	
					· .	-	

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Facility ID: 00722

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SANFPRD"

112 St. Olaf Avenue South Canby, Minnesota 56220 507-223-7277 www.sanfordcanby.org

DATE: 3/11/14

TO: Gail Anderson, MDH Unit Supervisor, Fergus Falls, MN

FROM: Nancy Salmon, Sylvan Court Administrator

- RE: Survey completed 1/30/14 Addendum to Plan of Correction
 - F167 At monthly QAPI meetings, each of the three RN Care Coordinators will report the number of care conferences conducted for their respective households for the preceding month, and the corresponding number of Sylvan Court Care Conference Review forms indicating that the resident was informed of the location of survey results. Reporting will continue until 3 months of 100% compliance have been achieved.
 - F248 / F282 Results of the audits will be reported at the monthly QAPI meeting. QAPI team will initiate further action if audit results don't trend upwards over a 3-month period.
 - F252 All staff were informed through shift-to-shift report and in writing that meals are to be removed from trays at the point of service. RN Care Coordinators will monitor for compliance and report on homelike dining environment at monthly QAPI meeting for 3 months.
 - F356 DON will report the number of daily postings returned to the Staffing Coordinator for the preceding month at monthly QAPI meetings. Formal reporting will be discontinued after 3 consecutive months of 100% compliance.
 - F371 Both verbal and written communication was given to all Dietary staff. Only Dietary staff prepares the plates of food for delivery to residents at meal time, so this communication covers all households and dining areas.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			R/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
245433			B. WING		01/30/2014		
SYLVAN COURT 112 ST				RESS, CITY, STATE, ZIP CODE OLAF AVENUE SOUTH 7, MN 56220			
(X4) ID PREFIX TAG	D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUL)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS			K 000			
<u>-</u>	FIRE SAFETY						
	A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Sylvan Court Canby Nursing Home was found 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.						
	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.						
	fire alarm system w corridors and space monitored for autom notification. The fac	sprinklered. The fac ith smoke detection es open to the corride natic fire department cility has a capacity o of 66 at time of the su	in the ors that is of 68 beds				
		IDER/SUPPLIER REPRESE		NATURE	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.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7002 0860 0006 5192 3940

February 21, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5433024

Dear Ms. Salmon:

The above facility was surveyed on January 27, 2014 through January 30, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The 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 Nursing Homes.

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 and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Sylvan Court February 21, 2014 Page 2

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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 1505 Pebble Lake Road #300 Fergus Falls Minnesota 56537. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at: (218) 332-5140.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Telephone: (651) 201-4118 Fax: (651) 215-9697 Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility Licensing and Certification File

5433s14lic.rtf

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED	
		00722	B. WING	0	01/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SYLVAN	COURT	112 ST OL CANBY, M	.AF AVENUI IN 56220	E SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	Department's staff the following licens corrections are com on the bottom of the with "Laboratory Di	FS: 29,30, 2014, surveyors of this visited the above provider and ing orders were issued. When ppleted, please sign and date e first page in the line marked rector's or Provider/Supplier gnature." Make a copy of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softwar Tag numbers have been assigned to Minnesota state statutes/rules for Nursin Homes.		

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

TITLE

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SU COMPLE	
		00722	B. WING		01/30/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SYLVAN	COURT		LAF AVENU MN 56220	E SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
	these orders for you original to the addre Minnesota Departm Gail Anderson, Unit 1505 Pebble Lake Fergus Falls, mn 56	nent of Health t Supervisor Road suite 300		The assigned tag number appear far left column entitled "ID Prefix The state statute/rule out of comp listed in the "Summary Statement Deficiencies" column and replace Comply" portion of the correction This column also includes the find which are in violation of the state after the statement, "This Rule is as evidence by." Following the su findings are the Suggested Metho Correction and Time period for C PLEASE DISREGARD THE HEA OF THE FOURTH COLUMN WH STATES, "PROVIDER'S PLAN O CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTI VIOLATIONS OF MINNESOTA S STATUTES/RULES.	Tag." Dliance is t of es the "To order. dings statute not met inveyors od of orrection. DING ICH F TO Y. THIS	
2 560	Plan of Care; Contents Subp. 2. Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The c must include the inc	of plan of care. The n of care must list measurable stables to meet the resident's m goals for medical, nursing, ychosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan sota Statutes, section 626.557,	2 560			

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		00722	B. WING	B. WING		30/2014
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SYLVAN	COURT		LAF AVENUE MN 56220	SOUTH		
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2 560	Continued From pa	ge 2	2 560			
	by: Based on interview facility failed to dev plan to identify diab	ent is not met as evidenced and document review, the elop a comprehensive care petic needs for 1 of 5 residents e reviewed for unnecessary				
	Findings include:					
	12/17/13, included	imum Data Set (MDS) dated severe cognitive impairment gnosis of diabetes mellitus.				
	included to check b	der report dated 1/29/14, lood sugar Monday through alternating times as well as				
	mood, physical care hospice care. The	t updated 1/6/14, addressed e, activities, comfort and care plan failed to identify the s and did not give directions iabetes.				
	registered nurse (R have a care plan th diabetes, then state have one, we shoul monitoring for hypo hyperglycemia [higl	1/29/14, at 2:05 p.m., N)-B confirmed R24 did not at addressed the problem of ed, "I can't believe we don't Id have one in there with glycemia [low blood sugar] or h blood sugar], accuchecks s], we normally do complete				

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NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
SYLVAN	COURT		DLAF AVENUE	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	ge 3	2 560			
	director of nursing (did not develop a co R24. The DON sta missed, she has be six years." The DO resident's care plan	1/30/14, at 11:56 a.m. the (DON) confirmed the facility omprehensive care plan for ted, "It should not have been een here a long time, at least on reported that each a should address active medications and treatments.				
	Interdisciplinary Pla	sment of Residents and in of Care Policy dated 11/10, v would assess and determine r each resident.				
	The director of nurs staff to develop a ca interventions for all monitoring program to assure ongoing a interventions in res	HOD OF CORRECTION: sing or designee could direct are plan to include appropriate identified care needs. A could be established in order and effective care plan ponse to resident care needs.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One	•			
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the				

F79W11

If continuation sheet 4 of 19

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00722	B. WING		01/	30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SYLVAN	COURT		MN 56220	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 565	Continued From pa	ige 4	2 565			
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview, and document ailed to provide activities as a plan for 1 of 3 residents activities.				
	interests in sports, listening music, cou	d 4/25/12, indicated R27 had especially a Vikings fan, easy untry music, old movies, piano ch, playing catch, and talking				
	room on 1/28/14, a Movies activity was in his reclining whe	in the Willow Lane dining t 9:39 a.m. A News and in process. R27 was asleep el chair and did not id not attempt to wake him				
	dining room at a tal R27 remained in th	to be in the Willow Lane ble on 1/28/14 at 2:00 p.m. e dining room while there was ty going on in a different room				
	at 10:45 a.m. A Sta	to be lying in bed on 1/29/14, anding Strong (exercise) as occurring elsewhere in the				
		sleeping in his wheel chair at ow Lane dining room on				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00722	B. WING		01/3	01/30/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
SYLVAN	COURT		DLAF AVENUE MN 56220	SOUTH			
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2 565	- · · · · · · · · · · · · · · · · · · ·	n. An activity was going on	2 565				
	nursing assistant (N been assisted to ar reviewed documen and verified the las in was documented of watching televisi	on 1/29/14, at 1:55 p.m. NA)-A stated R27 had not ny activities on 1/29/14. NA-A tation of activity participation t activity R27 had participated I as a 1:1 (one on one) activity on on 1/24/14. NA-A stated staff were responsible to get es and encourage	,				
	conducting Standin the chapel of the fa was observed seat	a.m. activity staff were g Strong exercise program in cility. During the activity R27 ed in the Willow Lane dining other residents around the ctivity.					
	seated at dining roo activity was occurri Registered nurse (I why R27 was not p stated, "He should been able to partici R27 could stand an further stated it was activity because he toileted prior to goin	a.m. R27 was observed om table by himself while an ng elsewhere in the facility. RN)-A was interviewed about articipating in activities. RN-A be in the activity as he has pate in the past." RN-A stated id walk with assist. RN-A s too late to take R27 to the needed to be checked and ng to the activity. RN-A stated, clean if he goes. We should					

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2 565	When interviewed of community living dii should be assisting encouraging him to R27 enjoyed music participate in the ex- confirmed R27's ca have been taken to and did not know w A policy was request facility. SUGGESTED MET The director of nurs train all staff to follo The DON or design random audits to er plan is being follow TIME PERIOD FOR (21) days.	on 1/30/14 at 10:05 a.m. , the rector (CLD)-B, stated staff R27 to activities and participate. CLD-B stated and would be able to sercise programs. CLD-B re plan and stated R27 should activities the past three days hy he had not been. Sted, but not provided by the CHOD OF CORRECTION: sing (DON) or designee could w each resident's care plan. ee could then perform nsure each residents care ed by all staff. R CORRECTION: Twenty One D Subp. 4 Dietary Staff				
	wash their hands and their arms with soan washing facility befor as often as is necess after smoking, eating handling soiled equi	Dietary staff must thoroughly nd the exposed portions of o and warm water in a hand ore starting work, during work ssary to keep them clean, and ng, drinking, using the toilet, or ipment or utensils. Dietary ir fingernails clean and				

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21000	Continued From pa	ge 7	21000			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to serve food in a sanitary manner to prevent the spread of food borne illness for 6 of 54 residents (R79, R20, R29, R2, and R65) who were served food in the Maple and Oak dining rooms					
	Findings include:					
	1/28/14, at 11:39 a. and filled out their r At 11:41 a.m. a resi out her menu slip, a from the table to the the menu slip up fro	in the Maple dining room on m., residents sat at the tables nenu slips for the noon meal. dent had just completed filling and the menu slip dropped e floor. A staff member picked om the floor and put the dirty other completed menu slips or the steam table.				
	type gloves on both going through the n	ary aide (DA)-B donned vinyl a hands. DA-B then started nenu slips, one by one, e of paper with both gloved				
	contaminated by th into a bag of deli ha ham slice in half an DA-B handled the s	ring the same gloves e menu slips, DA-B reached am with both hands, folded the d placed the ham on a plate. stack of menu slips between with the same gloves.				

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21000	Continued From pa	ige 8	21000			
	DA-B handled anot condiments from a table. DA-B immed bread from a plastic sandwich using the did not change her At 12:13 p.m., weat DA-B handled anot plate she prepared of deli ham two time hands, then reacher removed two piece make the sandwich gloves, DA-B handl reached into the ba bread with both glo assemble the ham place one dirty glow	ring the same dirty gloves, her menu slip, then picked up cart to the left of the steam diately removed two pieces of c bag and prepared a ham same gloved hands. DA-B gloves or wash her hands. ring the same dirty gloves, her menu slip for the next . DA-B reached into the bag es with the same gloved ed into the bag of bread and s of bread and proceeded to b. Wearing the same dirty led another menu slip, ng of deli ham and bag of ved hands, and proceeded to sandwich. DA-A proceeded to we hand over the entire he sandwich with the other				
		es made by DA-B, using dirty e served to R79, R20, R29,				
	confirmed she wore during the entire me handled each resid preparing each me handled ready to ea and bread, with the	1/28/14, at 12:31 p.m., DA-B e the same pair of gloves eal service, and verified she ent menu slip between al. DA-B confirmed she had at foods, including deli ham same contaminated gloves. I serve like that all the time."				

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21000	Continued From pa	ige 9	21000			
	dietary manager (D menu slips dirty, be item and others hav stated staff should	1/29/14, at 12:07 p.m., the M) stated she considered ecause they are not a food ve touched them. The DM change their gloves every time ninated item and staff have e past.	3			
	Oak dining room or was serving resider donned vinyl-type g the bottom drawer of retrieved an individe for a resident meal. out and removed a buttered the toast, I gloved hands, then	of the breakfast meal in the n 1/29/14, at 8:05 a.m. DA-A nt breakfast meals. DA-A gloves on both hands, opened on the steam table and ual pack of breakfast cereal . DA-A immediately reached slice of toast from the toaster, holding it with the same cut the toast and placed it on reakfast items and served the				
	of bread in the toas from the cart, picke juice, and poured ju the same gloves, D plastic bag of biscu table, and placed th Wearing the same of the steam table t toast from the toast	donned gloves, placed a slice ster, removed a drinking glass d up a container of apple uice into the glass. Wearing A-A proceeded to reach into a its on the top of the steam ne biscuit on a resident plate. gloves, DA-A opened drawers hen proceeded to remove the ter, placed the toast on a plate t items and served the meal to				

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21000	Continued From pa	ige 10	21000			
	serve resident mea gloves became cor be changed. DA-A observation finding realize cross conta The facility's Dietar dated 2/09, directed	stated it was usual practice to its with gloves, and if the itaminated, the gloves were to confirmed the above s and indicated she did not mination had happened. y Infection Control policy d staff to use proper food s to control the growth of				
	The Director Of Nu review and revise for procedures to assu sanitary manner. So necessary. The Ce monitor the service ensure staff are foll practices.	THOD OF CORRECTION: rsing and the Dietician could ood service policies and the that food is served in a Staff could be trained as ertified Dietary Manager could of food on a periodic basis to lowing safe food handling R CORRECTION: Twenty One				
	(21) days.					
21435	MN Rule 4658.090 Recreation Program	0 Subp. 1 Activity and n; General	21435			
	home must provide recreation program based on each indi	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to				

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21435	meet the physical, i well-being of each comprehensive res comprehensive pla 4658.0400 and 460 provided opportunit planning and devel recreation program This MN Requireme by: Based on observati review the facility fa services in a manne	mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ies to participate in the opment of the activity and				
	Findings include:					
	12/31/13, indicated with diagnoses inc disease, and depre R27 relied on staff assistance of two fo	imum Data Set (MDS) dated severe cognitive impairment luding dementia, Parkinson's ssion. The MDS indicated for locomotion, and extensive or ambulation. The annual 6, failed to identify any activity 7.				
	interest in sports, e listening music, cou	ed 4/25/12, indicated an specially a Vikings fan, easy intry music, old movies, piano, ch, playing catch, and talking				
		Preference Guide identified ing sports, soft music, country				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00722	B. WING		01/30/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DDRESS, CITY, ST	TATE, ZIP CODE		
SYLVAN	COURT		MN 56220	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	music, old movies,	age 12 piano, bird watching, church, activities that kept his hands	21435			
	room on 1/28/14, a Movies activity was in his reclining whe	in the Willow Lane dining t 9:39 a.m. A News and s in process. R27 was asleep el chair and did not id not attempt to wake him				
	dining room at a tal R27 remained in th	to be in the Willow Lane ble on 1/28/14 at 2:00 p.m. e dining room while there was ty going on in a different room				
	at 10:45 a.m. A Sta	to be lying in bed on 1/29/14, anding Strong (exercise) as occurring elsewhere in the				
	the table in the Will	sleeping in his wheel chair at low Lane dining room on n. An activity was going on cility.				
	nursing assistant (N been assisted to an reviewed document and verified the lass in was documented of watching television	on 1/29/14, at 1:55 p.m. NA)-A stated R27 had not ny activities on 1/29/14. NA-A tation of activity participation t activity R27 had participated d as a 1:1 (one on one) activity on on 1/24/14. NA-A stated staff were responsible to get				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLI	
		00722	B. WING		01/	30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
SYLVAN	COURT		MN 56220	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	ige 13	21435			
	residents to activition participation.	es and encourage				
	On 1/30/14 at 9:20 a.m. activity staff were conducting Standing Strong exercise program in the chapel of the facility. During the activity R27 was observed seated in the Willow Lane dining room at table with other residents around the table without any activity.					
	seated at dining roo activity was occurri Registered nurse (I why R27 was not p stated, "He should been able to partici R27 could stand an further stated it was activity because he toileted prior to goin	a.m. R27 was observed om table by himself while an ng elsewhere in the facility. RN)-A was interviewed about articipating in activities. RN-A be in the activity as he has pate in the past." RN-A stated ad walk with assist. RN-A s too late to take R27 to the e needed to be checked and ng to the activity. RN-A stated, clean if he goes. We should				
	community living di should be assisting encouraging him to R27 enjoyed music participate in the ex stated R27 should	on 1/30/14 at 10:05 a.m., the rector (CLD)-B, stated staff R27 to activities and participate. CLD-B stated and would be able to kercise programs. CLD-B have been taken to activities and did not know why he had				
	Even though R27 h	ad been assessed as				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00722	B. WING		01/	30/2014
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
SYLVAN	COURT		MN 56220	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	ge 14	21435			
	activity programs th had not been assis	g capable of participating in he facility had available, he ted to them, or encouraged to 14 through 1/30/14.				
	A policy was reque facility.	A policy was requested, but not provided by the facility.				
	The activity director each resident's ass	THOD OF CORRECTION: r could train all staff to ensure ressed activity preferences are audit to ensure this is				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One)			
21665	MN Rule 4658.140	0 Physical Environment	21665			
	functional, comforta environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.				
	by: Based on observati review, the facility f dining experience f R4, R32, R34, R33 R62, and R50) who	ent is not met as evidenced ion, interview, and document ailed to provide a home like or 12 of 12 residents (R45, , R27, R15, R47, R56, R23, o ate in the Willow dining reals were served on plastic				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00722	B. WING		01/	30/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	ADDRESS, CITY, STATE, ZIP CODE				
SYLVAN	COURT		MN 56220	SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
21665	Continued From pa	ge 15	21665				
	Findings Include:						
	R34, R33, R27, R1 R50 were sitting at gray plastic trays si this meal service, re	at 12:00 p.m. R45, R4, R32, 5, R47, R56, R23, R62 and the tables with food items on tting in front of them. During esidents on the Oak and erved meals off of a steam bared trays.					
	dining room, on 1/2 R32, R34, R27, R1 and R50, were sittin on eleven gray plas speckled tray, sittin at breakfast time withis meal service, ro	observation in the Willow 9/14, at 8:00 a.m. R45, R4, 5, R47, R56, R23, R33, R62 ng at tables with food items stic trays and one black g on the table in front of them hile they were eating. During esidents on the Oak and erved meals off of a steam bared trays.					
	12:00 p.m. R45, R4 R56, R23, R33, R6 table with food item on the table in front they were eating. I residents on the Oa	observation on 1/30/14, at k, R32, R34, R27, R15, R47, 2 and R50, were sitting at the as on gray plastic trays sitting of them at lunch time while During this meal service, ak and Maple units were a steam table, not off of					
	nutritional foods ma	on 1/30/14, at 8:40 a.m. the anager (NFM) stated only low dining room are served					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00722	B. WING	B. WING		30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
SYLVAN	COURT		MN 56220	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	their meals off a fo They started this ap because the extra s the residents anxio re-addressed this is even though this wa of doing things, and changed. The NFI being provided in a these residents. When interviewed of director of nursing (Willow dining room the steam table a fe residents had not b A facility policy entit dated 5/2011, inclu- meals served were procedure identified were provided by a 2nd floors for all thr residents being abl- like. The Unit resid steam table at the r policy did not addre Willow dining room	od cart, on prepared trays. pproximately three years ago staff and equipment had made us. They had not ssue in the past few years, as more of an institutional way 4 the resident population had W agreed meals were not home like environment for on 1/30/14, at 9:03 a.m. the DON) stated residents in the did not want food served from aw years ago. Current een consulted. ted Patient Meal Service ded a purpose of ensuring attractively presented. The d Senior Haven meal serves steam table going to 1st and ee meals and included With e to choose what they would ents were served from the noon and supper meal. The ess serving residents in the differently, on plastic trays. THOD OF CORRECTION: iee could educate staff and idits of areas residents a home like environment is	<i>,</i>			

F79W11

If continuation sheet 17 of 19

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00722	B. WING		01/30/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
SYLVAN	COURT	112 ST OL CANBY, M	AF AVENUE	SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	ge 17	21665			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21685		5 Subp. 2 Plant eration, & Maintenance	21685			
	Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program.					
	by: Based on observati review the facility fa sanitary equipment	ent is not met as evidenced on, interview and document ailed to maintain clean, in the main kitchen of the he potential to affect 66 of 66				
	Findings Include:					
	Food Manager (NF silver colored stove fryer and a convent large amount of dus down both side pan the side panels. Th amount of grease b stove. She stated d assigned to dietary	itchen with the Nutritional M), on 1/29/14, at 2:40 p.m. a was located between a deep ional oven. The stove had a st covered grease spilled hels, covering the majority of he NFM confirmed the large huild up on both sides of the ifferent cleaning duties are staff, however, cleaning the was not assigned to anyone.				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00722	B. WING		01/	30/2014
AME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE, ZIP CODE		
YLVAN	COURT		DLAF AVENUE MN 56220	SOUTH		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21685	Continued From pa	ge 18	21685			
	dietary personal po listed on each list, h	sts were provided for each sition, Cleaning Jobs were nowever, routine cleaning of ncluded on the cleaning lists.				
	SUGGESTED METHOD OF CORRECTION: The administrator could in-service employees who do cleaning of ovens and kitchen equipment on the need to keep it clean and sanitary.		t			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One	9			