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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: F79W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00722

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245433**
2.STATE VENDOR OR MEDICAID NO.
(L2) **490617900**

3. NAME AND ADDRESS OF FACILITY
(L3) **SYLVAN COURT**
(L4) **112 ST OLAF AVENUE SOUTH**
(L5) **CANBY, MN** (L6) **56220**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/19/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **68** (L18)

13.Total Certified Beds **68** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 03/30/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/02/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2014
(L33)

DETERMINATION APPROVAL

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

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 resuilts 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 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

cc: Licensing and Certification File

5433r14.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245433	A. Building B. Wing	3/20/2014

Name of Facility	Street Address, City, State, Zip Code
SYLVAN 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	(Y5) Date
ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **03/07/2014**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0252** Reg. # **483.15(h)(1)** LSC	Correction Completed **03/11/2014**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/11/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/11/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GA	03/30/2013	31256	03/1*/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/30/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: F79W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00722

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245433**

2.STATE VENDOR OR MEDICAID NO.
(L2) **490617900**

3. NAME AND ADDRESS OF FACILITY
(L3) **SYLVAN COURT**
(L4)
(L5) **112 ST OLAF AVENUE**
SOUTH CANBY, MN (L6) **56220**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/30/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **68** (L18)

13.Total Certified Beds **68** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	68			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 03/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Program Specialist 03/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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.

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by 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.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245433	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN COURT	112 ST OLAF AVENUE SOUTH CANBY, MN 56220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform 3 of 3 residents (R57, R38, and R39) where the state survey results were located in the facility. This practice had the potential to affect all 66 residents residing in the facility. Findings include:	F 167	It is the policy and practice of Sanford Sylvan Court to post Federal and State survey results and plan of correction prominently in a place readily visible and accessible to residents and visitors. The survey results have been and are posted on 2 of 3 households. A notice is posted on the 3rd household directing anyone interested to the location of the survey results. A wall-mounted 15"W x 13"H x 4"D vinyl holder is labeled "Survey Results" in 60 font size; black letters on white background at a height of 39 inches above the floor. 3/11/14 OK - addendum	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Salmon — TITLE: Administrator — (X6) DATE: 3/4/14

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.

RECEIVED
MAR 06 2014
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245433	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN COURT	112 ST OLAF AVENUE SOUTH CANBY, MN 56220

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 167	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 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 1/2/14, 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 the state survey results were located. During interview on 1/30/13, at 11:40 a.m., the	F 167	Survey Results The vinyl holder is located in a corridor between resident rooms and the dining/ living room and immediately adjacent to the Monthly Activity Calendar and Weekly Menus. Examination of Survey Results is a right afforded to residents and/or families and is communicated at the time of admission in a booklet, "Your Rights Under the Combined Federal and Minnesota Residents Bill of Rights." Residents 57, 38, and 39 were shown where the survey results are posted. A written communication was given to all residents describing the location of the posted survey results.	

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F 167	Continued From page 2 activity director (AD) stated she had reviewed the right to review state survey results greater than one year ago, but had not discussed this with residents since then. She confirmed any new residents or residents that had not attended the resident council meeting held greater than one year ago, would not be made aware of the right to review and the location of the survey results. The AD confirmed the resident council meeting was the setting to review resident rights, which included the right to review the state survey results and their location and confirmed this had not been done. Review of the facility's Resident Council Agenda template dated 2014, did not address the right to review state survey results. A policy was requested, but not provided by the facility.	F 167	Medical Record form #768.86, Sylvan Court Care Conference Review, has been revised to include a reminder to each resident of the location of posted survey results. This form is completed quarterly. The revised form will assure ongoing compliance. RN Care Coordinators who conduct the quarterly Care Conferences will complete the form.	3/7/14
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide activity services in a manner to meet the needs of 1 of 3 residents (R27) in the sample who were reviewed	F 248	It is the policy of Sylvan Court to provide leisure activities to meet the needs of each resident. Resident #27's activity care plan indicates that a minimum of two one-to-one activities be conducted with Resident #24 every week. Eleven one-to-one activities were documented for the month of January 2014. At least	

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F 248	Continued From page 3 for activities. Findings include: R27's quarterly Minimum Data Set (MDS) dated 12/31/13, indicated severe cognitive impairment with diagnoses including dementia, Parkinson's disease, and depression. The MDS indicated R27 relied on staff for locomotion, and extensive assistance of two for ambulation. The annual MDS dated 10/2/13, failed to identify any activity preferences for R27. R27's care plan dated 4/25/12, indicated an interest in sports, especially a Vikings fan, easy listening music, country music, old movies, piano, bird watching, church, playing catch, and talking to stuffed animals. An undated Activity Preference Guide identified R27 enjoyed watching sports, soft music, country music, old movies, piano, bird watching, church, playing catch, and activities that kept his hands busy. 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 activity. R27 was observed to be in the Willow Lane dining room at a table on 1/28/14 at 2:00 p.m. R27 remained in the dining room while there was	F 248	two one-to-ones were conducted every full week of the month. Two times during the month, the one-to-ones were 5 days apart. One-to-one's were documented on 1/24/14 and again on 1/29/14. The one-to-ones correlated with Resident #27's documented interests. Resident #27's Daily Activity Attendance Record indicates that Resident #27 participated in between 1 and 6 group activities 27 of the 31 days in January. Because of Resident #27's severe cognitive impairment, he benefits from basic, concrete physical interaction, like ball toss which he does do. Small group activities on the household where #27 resides are more appropriate to his functional level. Resident #27's passive presence at a group activity out of his usual environment aimed at more cognitively intact residents, such as a church service or Bible study, can be distressing to Resident #27 as evidenced by loud guttural noises and ataxic movements of extremities.	

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F 248	Continued From page 4 a Bible Study activity going on in a different room. R27 was observed to be lying in bed on 1/29/14, at 10:45 a.m. A Standing Strong (exercise) activity program was occurring elsewhere in the facility. R27 was observed sleeping in his wheel chair at the table in the Willow Lane dining room on 1/29/14, at 1:52 p.m. An activity was going on elsewhere in the facility. When interviewed on 1/29/14, at 1:55 p.m. nursing assistant (NA)-A stated R27 had not been assisted to any activities on 1/29/14. NA-A reviewed documentation of activity participation and verified the last activity R27 had participated in was documented as a 1:1 (one on one) activity of watching television on 1/24/14. NA-A stated the NA's or activity staff were responsible to get residents to activities and encourage participation. 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. On 1/30/14 at 9:35 a.m. R27 was observed seated at dining room table by himself while an activity was occurring elsewhere in the facility. Registered nurse (RN)-A was interviewed about	F 248	On days that staff sees that Resident #27 is more alert and responsive than usual, group activities, such as live music, may be attempted when offered. Resident #27's activity care plan was reviewed. When appropriate, staff will assist Resident #27 to attend on-site group activities. Religious music and tapes may be offered to Resident #24. Staff will document more of the one-to-one's and group activities over and above the care plan minimum that Resident #27 participates in. All of the care plans for residents in the same household as Resident #27 were reviewed, found be appropriate, and were being carried out as care planned. Care plans for residents with a dementia diagnosis, or residents with a history of non-participation in activities, on other households at Sylvan Court were reviewed by the Community Life Coordinator and respective RN Care Coordinators and found to be acceptable. The importance of documenting leisure activity	

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F 248	Continued From page 5 why R27 was not participating in activities. RN-A stated, "'He should be in the activity as he has been able to participate in the past." RN-A stated R27 could stand and walk with assist. RN-A further stated it was too late to take R27 to the activity because he needed to be checked and toileted prior to going to the activity. RN-A stated, "[R27] needs to be clean if he goes. We should have taken him." When interviewed on 1/30/14 at 10:05 a.m. , the community living director (CLD)-B, stated staff should be assisting R27 to activities and encouraging him to participate. CLD-B stated R27 enjoyed music and would be able to participate in the exercise programs. CLD-B stated R27 should have been taken to activities the past three days and did not know why he had not been. Even though R27 had been assessed as enjoying, and being capable of participating in activity programs the facility had available, he had not been assisted to them, or encouraged to participate on 1/28/14 through 1/30/14. A policy was requested, but not provided by the facility.	F 248	participation was communicated to all staff in writing. Two Performance Improvement random audits were and are being conducted monthly to assure compliance with activity care plans and the quality of leisure activities; 1) Individual one-to-ones, and 2) Household leisure pursuit groups. All staff are informed monthly of the results of the audits and areas for improvement. Activity care plans are reviewed quarterly by the Care Conference Team and updated as indicated by the Community Life Coordinator.	3/11/14
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings	F 252	Sylvan Court provides a homelike dining environment in four dining rooms located on the three facility households. Only sixteen residents live on Willow Household. 23 residents live on Maple	

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F 252	Continued From page 6 to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a home like dining experience for 12 of 12 residents (R45, R4, R32, R34, R33, R27, R15, R47, R56, R23, R62, and R50) who ate in the Willow dining room, when their meals were served on plastic food trays. Findings Include: During dining observation in the Willow dining room, on 1/28/14, at 12:00 p.m. R45, R4, R32, R34, R33, R27, R15, R47, R56, R23, R62 and R50 were sitting at the tables with food items on gray plastic trays sitting in front of them. During this meal service, residents on the Oak and Maple units were served meals off of a steam table, not off of prepared trays. During dining room observation in the Willow dining room, on 1/29/14, at 8:00 a.m. R45, R4, R32, R34, R27, R15, R47, R56, R23, R33, R62 and R50, were sitting at tables with food items on eleven gray plastic trays and one black speckled tray, sitting on the table in front of them at breakfast time while they were eating. During this meal service, residents on the Oak and Maple units were served meals off of a steam table, not off of prepared trays.	F 252	and 29 residents live on Oak. While Maple and Oak were constructed in the 1960's, Willow Household was constructed in 1999; the rooms in Willow are larger and ADA compliant making it more manageable for residents requiring the use of mechanical lifts or physical assist of two staff members in the toilet rooms. In addition, Willow has no through-traffic of laundry carts, meal carts, or waste carts; no overhead paging, and no direct exit to the outdoors; those features, along with the smaller population, make Willow a desirable household for residents who may be bothered by excess stimuli. Those residents often have a dementia diagnosis and may find making choices difficult or frustrating. Consequently, Willow Household has been better served by decreasing the activity and demand for choices at mealtime. Any Willow resident desiring to eat in one of the other dining rooms is given that option. Any Willow resident who	

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F 252	Continued From page 7 During dining room observation on 1/30/14, at 12:00 p.m. R45, R4, R32, R34, R27, R15, R47, R56, R23, R33, R62 and R50, were sitting at the table with food items on gray plastic trays sitting on the table in front of them at lunch time while they were eating. During this meal service, residents on the Oak and Maple units were served meals off of a steam table, not off of prepared trays. When interviewed on 1/30/14, at 8:40 a.m. the nutritional foods manager (NFM) stated only residents in the Willow dining room are served their meals off a food cart, on prepared trays. They started this approximately three years ago because the extra staff and equipment had made the residents anxious. They had not re-addressed this issue in the past few years, even though this was more of an institutional way of doing things, and the resident population had changed. The NFM agreed meals were not being provided in a home like environment for these residents. When interviewed on 1/30/14, at 9:03 a.m. the director of nursing (DON) stated residents in the Willow dining room did not want food served from the steam table a few years ago. Current residents had not been consulted. A facility policy entitled Patient Meal Service dated 5/2011, included a purpose of ensuring meals served were attractively presented. The procedure identified Senior Haven meal serves were provided by a steam table going to 1st and 2nd floors for all three meals and included With	F 252	would prefer making meal choices from the steam tables is given that option. Dining and nutrition are reviewed at least quarterly with each resident and/or family member who gives input at the Quarterly Care Conference. Plates, glasses, cups, silverware and any other utensils are removed from the tray and placed directly on the table or placemat for the residents in Willow. Trays are also removed before serving a meal to residents who choose to eat in their rooms. When residents have requested that their meal remain on a tray, their request is honored and care planned. Policy #803.401, Patient Meal Service, has been updated. The Willow RN Care Coordinator has addressed meal site and delivery preference with all current residents, and will address it at each resident's quarterly care conference.	3/11/14

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F 252	Continued From page 8 residents being able to choose what they would like. The Unit residents were served from the steam table at the noon and supper meal. The policy did not address serving residents in the Willow dining room differently, on plastic trays.	F 252		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to identify diabetic needs for 1 of 5 residents (R24) in the sample reviewed for unnecessary medications.	F 279	The care plan for R24 has been updated by RN Care Coordinator and DON to include addressing diagnosis of Diabetes Mellitus, goals for this problem, and interventions to carry out orders and cares. The care plans for all residents with Diabetes will be reviewed to assure all have Diabetes addressed. Policies and procedures for care planning have been reviewed and updated to include a new checklist to ascertain all active diagnoses are addressed on each resident's care plan. Nursing staff will be trained on this checklist via a "Read and Sign" instructional sheet. A Performance Improvement indicator will be set up by the DON to audit that the checklist is completed upon admission, with a hospital return, and	

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F 279	Continued From page 9 Findings include: R24's quarterly Minimum Data Set (MDS) dated 12/17/13, included severe cognitive impairment and included a diagnosis of diabetes mellitus. R24's physician order report dated 1/29/14, included to check blood sugar Monday through Friday once a day, alternating times as well as insulin. R24's care plan last updated 1/6/14, addressed mood, physical care, activities, comfort and hospice care. The care plan failed to identify the problem of diabetes and did not give directions for care for R24's diabetes. During interview on 1/29/14, at 2:05 p.m., registered nurse (RN)-B confirmed R24 did not have a care plan that addressed the problem of diabetes, then stated, "I can't believe we don't have one, we should have one in there with monitoring for hypoglycemia [low blood sugar] or hyperglycemia [high blood sugar], accuchecks [blood sugar checks], we normally do complete diabetic care plans." During interview on 1/30/14, at 11:56 a.m. the director of nursing (DON) confirmed the facility did not develop a comprehensive care plan for R24. The DON stated, "It should not have been missed, she has been here a long time, at least six years." The DON reported that each	F 279	with significant change in status when applicable. Audit will be conducted monthly by delegated nursing staff and findings will be reviewed quarterly at QAPI meetings.	3/11/14

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F 279	Continued From page 10 resident's care plan should address active disease processes, medications and treatments. The facility's Assessment of Residents and Interdisciplinary Plan of Care Policy dated 11/10, indicated the facility would assess and determine the care needed for each resident.	F 279	It is the policy of Sylvan Court to provide leisure activities to meet the needs of each resident.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide activities as directed by the care plan for 1 of 3 residents (R27) reviewed for activities. Findings include: The care plan dated 4/25/12, indicated R27 had interests in sports, especially a Vikings fan, easy listening music, country music, old movies, piano, bird watching, church, playing catch, and talking to stuffed animals. 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	F 282	Resident #27's activity care plan indicates that a minimum of two one-to-one activities be conducted with Resident #24 every week. Eleven one-to-one activities were documented for the month of January 2014. At least two one-to-ones were conducted every full week of the month. Two times during the month, the one-to-ones were 5 days apart. One-to-one's were documented on 1/24/14 and again on 1/29/14. The one-to-ones correlated with Resident #27's documented interests. Resident #27's Daily Activity Attendance Record indicates that Resident #27 participated in between 1 and 6 group activities 27 of the 31 days in January. Because of Resident #27's severe cognitive impairment, he benefits from basic, concrete physical interaction, like ball toss which he does do. Small group	

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F 282	Continued From page 11 activity. R27 was observed to be in the Willow Lane dining room at a table on 1/28/14 at 2:00 p.m. R27 remained in the dining room while there was a Bible Study activity going on in a different room. R27 was observed to be lying in bed on 1/29/14, at 10:45 a.m. A Standing Strong (exercise) activity program was occurring elsewhere in the facility. R27 was observed sleeping in his wheel chair at the table in the Willow Lane dining room on 1/29/14, at 1:52 p.m. An activity was going on elsewhere in the facility. When interviewed on 1/29/14, at 1:55 p.m. nursing assistant (NA)-A stated R27 had not been assisted to any activities on 1/29/14. NA-A reviewed documentation of activity participation and verified the last activity R27 had participated in was documented as a 1:1 (one on one) activity of watching television on 1/24/14. NA-A stated the NA's or activity staff were responsible to get residents to activities and encourage participation. 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.	F 282	activities on the household where #27 resides are more appropriate to his functional level. Resident #27's passive presence at a group activity out of his usual environment aimed at more cognitively intact residents, such as a church service or Bible study, can be distressing to Resident #27 as evidenced by loud guttural noises and ataxic movements of extremities. On days that staff sees that Resident #27 is more alert and responsive than usual, group activities, such as live music, may be attempted when offered. Resident #27's activity care plan was reviewed. When appropriate, staff will assist Resident #27 to attend on-site group activities. Religious music and tapes may be offered to Resident #24. Staff will document more of the one-to-one's and group activities over and above the care plan minimum that Resident #27 participates in. All of the care plans for residents in the same household as Resident #27 were reviewed, found be appropriate, and were being carried out as care planned.	

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F 282	Continued From page 12 On 1/30/14 at 9:35 a.m. R27 was observed seated at dining room table by himself while an activity was occurring elsewhere in the facility. Registered nurse (RN)-A was interviewed about why R27 was not participating in activities. RN-A stated, "He should be in the activity as he has been able to participate in the past." RN-A stated R27 could stand and walk with assist. RN-A further stated it was too late to take R27 to the activity because he needed to be checked and toileted prior to going to the activity. RN-A stated, "[R27] needs to be clean if he goes. We should have taken him." When interviewed on 1/30/14 at 10:05 a.m. , the community living director (CLD)-B, stated staff should be assisting R27 to activities and encouraging him to participate. CLD-B stated R27 enjoyed music and would be able to participate in the exercise programs. CLD-B confirmed R27's care plan and stated R27 should have been taken to activities the past three days and did not know why he had not been. A policy was requested, but not provided by the facility.	F 282	Care plans for residents with a dementia diagnosis, or residents with a history of non-participation in activities, on other households at Sylvan Court were reviewed by the Community Life Coordinator and respective RN Care Coordinators and found to be acceptable. The importance of documenting leisure activity participation was communicated to all staff in writing. Two Performance Improvement random audits were and are being conducted monthly to assure compliance with activity care plans and the quality of leisure activities; 1) Individual one-to-ones, and 2) Household leisure pursuit groups. All staff are informed monthly of the results of the audits and areas for improvement.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked	F 356	Activity care plans are reviewed quarterly by the Care Conference Team and updated as indicated by the Community Life Coordinator.	3/11/14

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	245433	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN COURT	112 ST OLAF AVENUE SOUTH CANBY, MN 56220

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F 356	Continued From page 13 by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the daily nurse staffing information included resident census, and the actual hours worked by each category of nursing staff. This had the potential to affect all 66 current residents, as well as any family or visitors who may choose to view this information. Findings include:	F 356	It has been and is Sylvan Court's practice to post the daily nurse staffing levels by each shift and by each category of nursing staff. Daily census and shift start times and shift duration have been added to the posting. It remains the Staffing Coordinator's responsibility to post the initial information, the charge nurse to update the document if/when staffing or census changes, and the night nurse to switch the posting to the current day. The night nurse will route the past day's posting back to the Staffing Coordinator to close the loop. The Staffing Coordinator will verify that census and staffing changes were noted, and report to the DON.	3/11/14

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F 356	Continued From page 14 During the initial tour on 1/27/14, at 6:10 p.m. the required posting of nurse staffing information was observed on a wall directly across from the nurses station. The posting did not include the resident census, or the actual hours worked by each category of nursing staff. On 1/28/14 and 1/29/14, again the nurse staffing information failed to include the resident census or actual hours worked by each category of nursing staff. During interview on 1/29/14, at 7:30 a.m. registered nurse (RN)-B reported the staffing coordinator is responsible to post the nurse staff information daily. RN-B stated the nursing staff did not edit or change the information on the form after the staffing coordinator completed the form. During interview on 1/29/14, at 8:39 a.m. the staffing coordinator (SC) stated he was only responsible for the development of the nurse staff posting. The SC reported he put the next days posting behind the current posting by 4:00 p.m. each day, and stated nursing staff were supposed to switch the posting when the date changes. The SC confirmed that the posting did not include the resident census and did not identify the actual hours worked for registered nurses, licensed practical nurses, and certified nurse aides. During interview on 1/29/14, at 8:41 a.m. the director of nursing (DON) stated it was the night shift nurse's responsibility to switch the nurse staff posting to the current date. The DON confirmed the posting lacked the resident census and actual hours worked in each category, then	F 356		

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F 356	Continued From page 15 stated,"Something must have gotten changed on there and I was not aware of it." A policy was requested but not provided by the facility.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This 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: During observation in the Maple dining room on 1/28/14, at 11:39 a.m., residents sat at the tables and filled out their menu slips for the noon meal. At 11:41 a.m. a resident had just completed filling out her menu slip, and the menu slip dropped	F 371	It is the policy of Sylvan Court to serve food in a sanitary manner. The staff member who picked up the menu slip from the floor was not identified. All nursing and dietary staff have been reminded that items which have had contact with the floor must be discarded or sanitized. The NFS Manager talked with DA-A and DA-B about the observed breach of protocol. DA-A and DA-B indicated that they understood the error and what the correct procedure was. Dietary staff were given instruction on 2/19/14 on hand hygiene, identifying clean and dirty surfaces, and were given specific scenarios (including those cited) by the NFS Manager and Supervisor. Several serving processes were streamlined to enhance compliance:	

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F 371	Continued From page 16 from the table to the floor. A staff member picked the menu slip up from the floor and put the dirty menu slip with the other completed menu slips on a silver cart next to the steam table. At 12:04 p.m., dietary aide (DA)-B donned vinyl type gloves on both hands. DA-B then started going through the menu slips, one by one, touching each piece of paper with both gloved hands. At 12:09 p.m., wearing the same gloves contaminated by the menu slips, DA-B reached into a bag of deli ham with both hands, folded the ham slice in half and placed the ham on a plate. DA-B handled the stack of menu slips between each plate served with the same gloves. At 12:12 p.m., wearing the same dirty gloves, DA-B handled another menu slip, then picked up condiments from a cart to the left of the steam table. DA-B immediately removed two pieces of bread from a plastic bag and prepared a ham sandwich using the same gloved hands. DA-B did not change her gloves or wash her hands. At 12:13 p.m., wearing the same dirty gloves, DA-B handled another menu slip for the next plate she prepared. DA-B reached into the bag of deli ham two times with the same gloved hands, then reached into the bag of bread and removed two pieces of bread and proceeded to make the sandwich. Wearing the same dirty gloves, DA-B handled another menu slip, reached into the bag of deli ham and bag of bread with both gloved	F 371	- tongs will be used to pick up items such as sandwich meat instead of touching the item directly, - all items needed from the steam table drawer will be removed before serving begins, - the dishing process has been engineered so that the server will not touch the menus. The Infection Control policy for the Dietary department and the IC policy regarding hand hygiene have been reviewed and revised as indicated. A hand hygiene in-service specific to food service will be conducted two times per year by the NFS Manager and Supervisor. The NFS Manager and Supervisor have done random observations of food being served on the households. An audit tool for food service on the households will be implemented and reported on at QAPI and Dietary Staff Meetings conducted at least quarterly.	3/11/14

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F 371	Continued From page 17 hands, and proceeded to assemble the ham sandwich. DA-A proceeded to place one dirty gloved hand over the entire sandwich and cut the sandwich with the other dirty gloved hand. The ham sandwiches made by DA-B, using dirty gloved hands, were served to R79, R20, R29, and R2. During interview of 1/28/14, at 12:31 p.m., DA-B confirmed she wore the same pair of gloves during the entire meal service, and verified she handled each resident menu slip between preparing each meal. DA-B confirmed she had handled ready to eat foods, including deli ham and bread, with the same contaminated gloves. DA-B then stated, "I serve like that all the time." During interview on 1/29/14, at 12:07 p.m., the dietary manager (DM) stated she considered menu slips dirty, because they are not a food item and others have touched them. The DM stated staff should change their gloves every time they touch a contaminated item and staff have been told this in the past.	F 371		

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F 371	Continued From page 18	F 371		

During observation of the breakfast meal in the Oak dining room on 1/29/14, at 8:05 a.m. DA-A was serving resident breakfast meals. DA-A donned vinyl-type gloves on both hands, opened the bottom drawer on the steam table and retrieved an individual pack of breakfast cereal for a resident meal. DA-A immediately reached out and removed a slice of toast from the toaster, buttered the toast, holding it with the same gloved hands, then cut the toast and placed it on a plate with other breakfast items and served the meal to R65.

At 8:11 a.m., DA-A donned gloves, placed a slice of bread in the toaster, removed a drinking glass from the cart, picked up a container of apple juice, and poured juice into the glass. Wearing the same gloves, DA-A proceeded to reach into a plastic bag of biscuits on the top of the steam table, and placed the biscuit on a resident plate. Wearing the same gloves, DA-A opened drawers of the steam table then proceeded to remove the toast from the toaster, placed the toast on a plate with other breakfast items and served the meal to R2.

At 8:25 a.m., DA-A stated it was usual practice to serve resident meals with gloves, and if the gloves became contaminated, the gloves were to be changed. DA-A confirmed the above observation findings and indicated she did not

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F 371	Continued From page 19 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 371		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document 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 residents. Findings Include: During tour of the kitchen with the Nutritional Food Manager (NFM), on 1/29/14, at 2:40 p.m. a silver colored stove was located between a deep fryer and a conventional oven. The stove had a large amount of dust covered grease spilled down both side panels, covering the majority of the side panels. The NFM confirmed the large amount of grease build up on both sides of the stove. She stated different cleaning duties are assigned to dietary staff, however, cleaning the sides of the stove was not assigned to anyone.	F 465	It is the practice of Sylvan Court to maintain a clean and sanitary kitchen. The stove and the fryer have generally been positioned side-by-side, flush with each other. Grease spatters were contained because there was no space between the two appliances. These two appliances were moved apart at some point (for cleaning or service) and not moved back together. The grease on the sides of the oven and fryer was cleaned off. The floor between the two appliances was cleaned. The two appliances were moved flush with each other. Shift Position Task Lists have been reviewed and updated. Oven cleaning has been assigned to Shift Position #C2.	

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F 465	Continued From page 20 Undated Position lists were provided for each dietary personal position, Cleaning Jobs were listed on each list, however, routine cleaning of the stove was not included on the cleaning lists.	F 465	Cleaning for all areas, appliances, equipment, and surfaces have been assigned to a specific Shift Position. Weekly audits of all kitchen areas, appliances, equipment, and surfaces will be conducted by an individual other than the person assigned to clean that particular area to assure that cleaning is being done as frequently and thoroughly as directed. The NFS Supervisor or Manager will make weekly audit assignments and review them for variances. Audit results will be a standing agenda item for Dietary department meetings, written communications, and QAPI.	3/11/14

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

F5433022

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	245433	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/30/2014**

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K 000	INITIAL COMMENTS 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. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 68 beds and had a census of 66 at time of the survey.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00722	A. BUILDING: _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYLVAN COURT	112 ST OLAF AVENUE SOUTH CANBY, MN 56220

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On January 27, 28, 29,30, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health Gail Anderson, Unit Supervisor 1505 Pebble Lake Road suite 300 Fergus Falls, mn 56537	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b).	2 560		

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	00722	A. BUILDING: _____ B. WING _____	01/30/2014

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2 560	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan to identify diabetic needs for 1 of 5 residents (R24) in the sample reviewed for unnecessary medications. Findings include: R24's quarterly Minimum Data Set (MDS) dated 12/17/13, included severe cognitive impairment and included a diagnosis of diabetes mellitus. R24's physician order report dated 1/29/14, included to check blood sugar Monday through Friday once a day, alternating times as well as insulin. R24's care plan last updated 1/6/14, addressed mood, physical care, activities, comfort and hospice care. The care plan failed to identify the problem of diabetes and did not give directions for care for R24's diabetes. During interview on 1/29/14, at 2:05 p.m., registered nurse (RN)-B confirmed R24 did not have a care plan that addressed the problem of diabetes, then stated, "I can't believe we don't have one, we should have one in there with monitoring for hypoglycemia [low blood sugar] or hyperglycemia [high blood sugar], accuchecks [blood sugar checks], we normally do complete diabetic care plans."	2 560		

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2 560	Continued From page 3 During interview on 1/30/14, at 11:56 a.m. the director of nursing (DON) confirmed the facility did not develop a comprehensive care plan for R24. The DON stated, "It should not have been missed, she has been here a long time, at least six years." The DON reported that each resident's care plan should address active disease processes, medications and treatments. The facility's Assessment of Residents and Interdisciplinary Plan of Care Policy dated 11/10, indicated the facility would assess and determine the care needed for each resident. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		

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2 565	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide activities as directed by the care plan for 1 of 3 residents (R27) reviewed for activities. Findings include: The care plan dated 4/25/12, indicated R27 had interests in sports, especially a Vikings fan, easy listening music, country music, old movies, piano, bird watching, church, playing catch, and talking to stuffed animals. 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 activity. R27 was observed to be in the Willow Lane dining room at a table on 1/28/14 at 2:00 p.m. R27 remained in the dining room while there was a Bible Study activity going on in a different room. R27 was observed to be lying in bed on 1/29/14, at 10:45 a.m. A Standing Strong (exercise) activity program was occurring elsewhere in the facility. R27 was observed sleeping in his wheel chair at the table in the Willow Lane dining room on	2 565		

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2 565	Continued From page 5 1/29/14, at 1:52 p.m. An activity was going on elsewhere in the facility. When interviewed on 1/29/14, at 1:55 p.m. nursing assistant (NA)-A stated R27 had not been assisted to any activities on 1/29/14. NA-A reviewed documentation of activity participation and verified the last activity R27 had participated in was documented as a 1:1 (one on one) activity of watching television on 1/24/14. NA-A stated the NA's or activity staff were responsible to get residents to activities and encourage participation. 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. On 1/30/14 at 9:35 a.m. R27 was observed seated at dining room table by himself while an activity was occurring elsewhere in the facility. Registered nurse (RN)-A was interviewed about why R27 was not participating in activities. RN-A stated, "He should be in the activity as he has been able to participate in the past." RN-A stated R27 could stand and walk with assist. RN-A further stated it was too late to take R27 to the activity because he needed to be checked and toileted prior to going to the activity. RN-A stated, "[R27] needs to be clean if he goes. We should have taken him."	2 565		

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2 565	Continued From page 6 When interviewed on 1/30/14 at 10:05 a.m. , the community living director (CLD)-B, stated staff should be assisting R27 to activities and encouraging him to participate. CLD-B stated R27 enjoyed music and would be able to participate in the exercise programs. CLD-B confirmed R27's care plan and stated R27 should have been taken to activities the past three days and did not know why he had not been. A policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff to follow each resident's care plan. The DON or designee could then perform random audits to ensure each residents care plan is being followed by all staff. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed.	21000		

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21000	Continued From page 7 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: During observation in the Maple dining room on 1/28/14, at 11:39 a.m., residents sat at the tables and filled out their menu slips for the noon meal. At 11:41 a.m. a resident had just completed filling out her menu slip, and the menu slip dropped from the table to the floor. A staff member picked the menu slip up from the floor and put the dirty menu slip with the other completed menu slips on a silver cart next to the steam table. At 12:04 p.m., dietary aide (DA)-B donned vinyl type gloves on both hands. DA-B then started going through the menu slips, one by one, touching each piece of paper with both gloved hands. At 12:09 p.m., wearing the same gloves contaminated by the menu slips, DA-B reached into a bag of deli ham with both hands, folded the ham slice in half and placed the ham on a plate. DA-B handled the stack of menu slips between each plate served with the same gloves.	21000		

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21000	Continued From page 8 At 12:12 p.m., wearing the same dirty gloves, DA-B handled another menu slip, then picked up condiments from a cart to the left of the steam table. DA-B immediately removed two pieces of bread from a plastic bag and prepared a ham sandwich using the same gloved hands. DA-B did not change her gloves or wash her hands. At 12:13 p.m., wearing the same dirty gloves, DA-B handled another menu slip for the next plate she prepared. DA-B reached into the bag of deli ham two times with the same gloved hands, then reached into the bag of bread and removed two pieces of bread and proceeded to make the sandwich. Wearing the same dirty gloves, DA-B handled another menu slip, reached into the bag of deli ham and bag of bread with both gloved hands, and proceeded to assemble the ham sandwich. DA-A proceeded to place one dirty gloved hand over the entire sandwich and cut the sandwich with the other dirty gloved hand. The ham sandwiches made by DA-B, using dirty gloved hands, were served to R79, R20, R29, and R2. During interview of 1/28/14, at 12:31 p.m., DA-B confirmed she wore the same pair of gloves during the entire meal service, and verified she handled each resident menu slip between preparing each meal. DA-B confirmed she had handled ready to eat foods, including deli ham and bread, with the same contaminated gloves. DA-B then stated, "I serve like that all the time."	21000		

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21000	Continued From page 9 During interview on 1/29/14, at 12:07 p.m., the dietary manager (DM) stated she considered menu slips dirty, because they are not a food item and others have touched them. The DM stated staff should change their gloves every time they touch a contaminated item and staff have been told this in the past. During observation of the breakfast meal in the Oak dining room on 1/29/14, at 8:05 a.m. DA-A was serving resident breakfast meals. DA-A donned vinyl-type gloves on both hands, opened the bottom drawer on the steam table and retrieved an individual pack of breakfast cereal for a resident meal. DA-A immediately reached out and removed a slice of toast from the toaster, buttered the toast, holding it with the same gloved hands, then cut the toast and placed it on a plate with other breakfast items and served the meal to R65. At 8:11 a.m., DA-A donned gloves, placed a slice of bread in the toaster, removed a drinking glass from the cart, picked up a container of apple juice, and poured juice into the glass. Wearing the same gloves, DA-A proceeded to reach into a plastic bag of biscuits on the top of the steam table, and placed the biscuit on a resident plate. Wearing the same gloves, DA-A opened drawers of the steam table then proceeded to remove the toast from the toaster, placed the toast on a plate with other breakfast items and served the meal to R2.	21000		

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21000	Continued From page 10 At 8:25 a.m., DA-A stated it was usual practice to serve resident meals with gloves, and if the gloves became contaminated, the gloves were to be changed. DA-A confirmed the above observation findings and indicated she did not 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. SUGGESTED METHOD OF CORRECTION: The Director Of Nursing and the Dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis to ensure staff are following safe food handling practices. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21000		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to	21435		

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21435	Continued From page 11 meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide activity services in a manner to meet the needs of 1 of 3 residents (R27) in the sample who were reviewed for activities. Findings include: R27's quarterly Minimum Data Set (MDS) dated 12/31/13, indicated severe cognitive impairment with diagnoses including dementia, Parkinson's disease, and depression. The MDS indicated R27 relied on staff for locomotion, and extensive assistance of two for ambulation. The annual MDS dated 10/2/13, failed to identify any activity preferences for R27. R27's care plan dated 4/25/12, indicated an interest in sports, especially a Vikings fan, easy listening music, country music, old movies, piano, bird watching, church, playing catch, and talking to stuffed animals. An undated Activity Preference Guide identified R27 enjoyed watching sports, soft music, country	21435		

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21435	Continued From page 12 music, old movies, piano, bird watching, church, playing catch, and activities that kept his hands busy. 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 activity. R27 was observed to be in the Willow Lane dining room at a table on 1/28/14 at 2:00 p.m. R27 remained in the dining room while there was a Bible Study activity going on in a different room. R27 was observed to be lying in bed on 1/29/14, at 10:45 a.m. A Standing Strong (exercise) activity program was occurring elsewhere in the facility. R27 was observed sleeping in his wheel chair at the table in the Willow Lane dining room on 1/29/14, at 1:52 p.m. An activity was going on elsewhere in the facility. When interviewed on 1/29/14, at 1:55 p.m. nursing assistant (NA)-A stated R27 had not been assisted to any activities on 1/29/14. NA-A reviewed documentation of activity participation and verified the last activity R27 had participated in was documented as a 1:1 (one on one) activity of watching television on 1/24/14. NA-A stated the NA's or activity staff were responsible to get	21435		

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21435	Continued From page 13 residents to activities and encourage participation. 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. On 1/30/14 at 9:35 a.m. R27 was observed seated at dining room table by himself while an activity was occurring elsewhere in the facility. Registered nurse (RN)-A was interviewed about why R27 was not participating in activities. RN-A stated, '"He should be in the activity as he has been able to participate in the past." RN-A stated R27 could stand and walk with assist. RN-A further stated it was too late to take R27 to the activity because he needed to be checked and toileted prior to going to the activity. RN-A stated, "[R27] needs to be clean if he goes. We should have taken him." When interviewed on 1/30/14 at 10:05 a.m. , the community living director (CLD)-B, stated staff should be assisting R27 to activities and encouraging him to participate. CLD-B stated R27 enjoyed music and would be able to participate in the exercise programs. CLD-B stated R27 should have been taken to activities the past three days and did not know why he had not been. Even though R27 had been assessed as	21435		

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21435	Continued From page 14 enjoying, and being capable of participating in activity programs the facility had available, he had not been assisted to them, or encouraged to participate on 1/28/14 through 1/30/14. A policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The activity director could train all staff to ensure each resident's assessed activity preferences are honored, and then audit to ensure this is occurring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21435		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a home like dining experience for 12 of 12 residents (R45, R4, R32, R34, R33, R27, R15, R47, R56, R23, R62, and R50) who ate in the Willow dining room, when their meals were served on plastic food trays.	21665		

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21665	Continued From page 15 Findings Include: During dining observation in the Willow dining room, on 1/28/14, at 12:00 p.m. R45, R4, R32, R34, R33, R27, R15, R47, R56, R23, R62 and R50 were sitting at the tables with food items on gray plastic trays sitting in front of them. During this meal service, residents on the Oak and Maple units were served meals off of a steam table, not off of prepared trays. During dining room observation in the Willow dining room, on 1/29/14, at 8:00 a.m. R45, R4, R32, R34, R27, R15, R47, R56, R23, R33, R62 and R50, were sitting at tables with food items on eleven gray plastic trays and one black speckled tray, sitting on the table in front of them at breakfast time while they were eating. During this meal service, residents on the Oak and Maple units were served meals off of a steam table, not off of prepared trays. During dining room observation on 1/30/14, at 12:00 p.m. R45, R4, R32, R34, R27, R15, R47, R56, R23, R33, R62 and R50, were sitting at the table with food items on gray plastic trays sitting on the table in front of them at lunch time while they were eating. During this meal service, residents on the Oak and Maple units were served meals off of a steam table, not off of prepared trays. When interviewed on 1/30/14, at 8:40 a.m. the nutritional foods manager (NFM) stated only residents in the Willow dining room are served	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00722	A. BUILDING: _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21665	Continued From page 16 their meals off a food cart, on prepared trays. They started this approximately three years ago because the extra staff and equipment had made the residents anxious. They had not re-addressed this issue in the past few years, even though this was more of an institutional way of doing things, and the resident population had changed. The NFM agreed meals were not being provided in a home like environment for these residents. When interviewed on 1/30/14, at 9:03 a.m. the director of nursing (DON) stated residents in the Willow dining room did not want food served from the steam table a few years ago. Current residents had not been consulted. A facility policy entitled Patient Meal Service dated 5/2011, included a purpose of ensuring meals served were attractively presented. The procedure identified Senior Haven meal serves were provided by a steam table going to 1st and 2nd floors for all three meals and included With residents being able to choose what they would like. The Unit residents were served from the steam table at the noon and supper meal. The policy did not address serving residents in the Willow dining room differently, on plastic trays. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff and conduct periodic audits of areas residents frequent to ensure a home like environment is obtained to the extent possible.	21665		

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21665	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21665		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document 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 residents. Findings Include: During tour of the kitchen with the Nutritional Food Manager (NFM), on 1/29/14, at 2:40 p.m. a silver colored stove was located between a deep fryer and a conventional oven. The stove had a large amount of dust covered grease spilled down both side panels, covering the majority of the side panels. The NFM confirmed the large amount of grease build up on both sides of the stove. She stated different cleaning duties are assigned to dietary staff, however, cleaning the sides of the stove was not assigned to anyone.	21685		

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21685	Continued From page 18 Undated Position lists were provided for each dietary personal position, Cleaning Jobs were listed on each list, however, routine cleaning of the stove was not included 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. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21685		