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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ITKD

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 **06/01/2016** (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 **58** (L18)
13.Total Certified Beds **58** (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:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(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):

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 06/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/12/2016 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/31/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245433

July 12, 2016

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 May 16, 2016 the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 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 eNotice.

Sincerely,

Mark Meath

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 8, 2016

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

RE: Project Number S5433026

Dear Ms. Salmon:

On April 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 14, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 5, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 16, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 14, 2016, effective May 16, 2016 and therefore remedies outlined in our letter to you dated April 21, 2016, 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.

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245433	A. Building B. Wing	6/1/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242 Reg. # 483.15(b) LSC	Correction Completed 05/16/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 05/06/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 05/16/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GA/mm	06/08/2016	32603	06/01/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/14/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245433 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/5/2016 Y3

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	04/21/2016	LSC K0025	04/25/2016	LSC K0038	04/29/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	04/29/2016	LSC K0144	04/19/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	06/08/2016	36536	05/05/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
[ ]				

FOLLOWUP TO SURVEY COMPLETED ON
4/13/2016

[ ] 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: ITKD

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: **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 **04/14/2016** (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 **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	58			
(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):

17. SURVEYOR SIGNATURE — Date :
Beth Nowling, HFE NE II — 05/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/19/2016 (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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 21, 2016

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

RE: Project Number S5468026

Dear Ms. Salmon:

On April 14, 2016, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Email: gail.anderson@state.mn.us
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 May 24, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 24, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 July 14, 2016 (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 October 14, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

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

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 _____	04/14/2016

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. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide bathing based on resident preference for 1 of 2 residents (R52) reviewed for choices. Findings Include: Review of R52's quarterly Minimum Data Set (MDS) dated 12/31/15, identified R52 had diagnoses which included major depressive	F 242	It is the policy of Sylvan Court to honor a resident□s right to make choices and to communicate this choice verbally or via care plan and grid sheet to frontline staff. Resident #52 was re-interviewed by RNCC on 4/14/16 to verify her wishes for type of bath. Her expressed choice was for 1 tub bath a week and 1 shower per week. Care plan and grid sheets were adjusted to accommodate her wishes.	5/16/16

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

Electronically Signed | 05/02/2016

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 _____	04/14/2016

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 242	Continued From page 1 disorder, anxiety and chronic pain. The MDS identified R52 was cognitively intact, required extensive assistance with all activities of daily living (ADL's) including bathing and preferred a tub bath. Review of R52's admission MDS dated 10/6/15, identified R52 had been interviewed on her personal preferences and identified it was very important to R52 to choose what type of bath she had preferred. Review of R52's care plan dated 9/24/15, revealed R52 desired a bath and required extensive assist of two to transfer and assist of one to bathe. R52's care also listed it was very important to her to choose a TUB BATH !!! Review of R52's care grid printed 4/12/16, revealed R52 required assistance of one staff on Wednesdays and Sunday am's for a bath. Review of R52's care conference review forms dated 10/14/15, and 1/12/16, both lacked documentation regarding personal preferences for type of bath R54 preferred. On 4/11/16, at 6:44 p.m. R52 stated she had not been given the choice on what type of bathing she preferred. R52 stated she had received a shower, though preferred a tub bath. On 4/13/16, at 8:17 a.m. during a follow up interview, R52 stated she had received a shower that morning and would have preferred a bath. R52 stated she had thought she was asked by staff after she was admitted about what type of bathing she preferred. R52 stated she had told the staff she would prefer a bath and not a	F 242	New comprehensive resident choice assessment will be implemented May 6, 2016. We will begin using the assessment for all new admissions beginning May 6, 2016 and will assign to have completed on each current resident by May 16, 2016. Policy referring to resident choice will be updated by May 6, 2016 to reflect the new assessment process. Staff education on resident choice and the new assessment process will be completed by May 6, 2016. DON will develop audit tool regarding resident choice by May 6, 2016. This audit will be completed monthly x 3 months for all residents. Audit findings will be shared at monthly QAPI meetings x 3 months and also reported to Medical Executive Committee on a quarterly basis for that 3 month period.	

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F 242	Continued From page 2	F 242		

shower. R52 stated she did not recall having had a bath since her admission.

On 4/13/16, at 1:36 p.m. nursing assistant (NA)-A stated R52 was showered twice a week on Wednesday and Sundays. NA-A stated R52 had received a shower that morning and was unaware R52 preferred a bath. NA-A stated residents preference for bathing would be listed on the residents care grid. NA-A stated she would follow resident care grids to determine what type of cares and assistance the resident needed. NA-A was unaware R52's care grid had identified she preferred a tub bath.

On 4/13/16, at 1:37 p.m. NA-B stated R52 received a shower twice a week and was unaware R52 preferred a bath and not a shower.

On 4/13/16, at 2:44 p.m. registered nurse (RN)-A stated she was under the impression R52 had preferred showers. RN-A confirmed R52's care plan had indicated it was very important for R52 to have a tub bath. RN-A stated residents were asked quarterly with care conferences about bathing preference and was unaware R52 did not want a shower. RN-A confirmed R52's care conference review forms dated 10/14/15, and 1/12/16, both lacked R52's bathing preference.

On 4/3/16, at 3:09 p.m. the director of nursing (DON) verified R52's care grid sheet and care plan. The DON stated the facility's usual process to determine resident bathing preference was the activity director would ask the resident at the time of admission and care planned per resident preference. The DON stated she expected residents bathing preferences to be honored. The DON stated she expected residents to be asked

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F 242	Continued From page 3 quarterly with care conferences regarding their bathing preferences, as well as to ask if any changes needed to be made. Review of a facility policy titled Assessment of Residents and Interdisciplinary Plan of Care, revised 11/15, revealed a facility purpose for an interdisciplinary process to meet individualized needs of the residents for necessary care and services to attain or maintain their highest practicable level of well being. The policy directed facility staff to assess each residents personal preferences and to incorporate resident preferences into their plan of care. The policy directed staff to communicate residents plan of care to all persons involved in that residents care.	F 242		
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 implment the plan of care for bathing preferences for 1 or 2 residents (R52) reviewed for choices and for 1 of 3 residents (R54) reviewed for activities of daily living (ADLs) who were dependent on staff. Findings Include: Review of R52's care plan dated 9/24/15, revealed R52 desired a bath and required	F 282	Care plan and grid sheet for Resident #52 was updated on 4/15/16 to reflect resident□s wishes of 1 shower per week and one tub bath per week. All other residents will be interviewed by May 6, 2016 to make sure they have had no changes in preference since most recent care conference. If any have changes, their care plans and grid sheets will also be updated by May 6, 2016. DON will develop audit tool regarding care	5/6/16

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F 282	Continued From page 4 extensive assist of two to transfer and assist of one to bathe. R52's care also listed it was very important to her to choose a TUB BATH !!! On 4/11/16, at 6:44 p.m. R52 stated she had not been given the choice on what type of bathing she preferred. R52 stated she had received a shower, though preferred a tub bath. On 4/13/16, at 8:17 a.m. during a follow up interview, R52 stated she had received a shower that morning and would have preferred a bath. R52 stated she had thought she was asked by staff after she was admitted about what type of bathing she preferred. R52 stated she had told the staff she would prefer a bath and not a shower. R52 stated she did not recall having had a bath since her admission. On 4/13/16, at 1:36 p.m. nursing assistant (NA)-A stated R52 was showered twice a week on Wednesday and Sundays. NA-A stated R52 had received a shower that morning and was unaware R52 preferred a bath. NA-A stated residents preference for bathing would be listed on the residents care grid. NA-A stated she would follow resident care grids to determine what type of cares and assistance the resident needed. NA-A was unaware R52's care grid had identified she preferred a tub bath. On 4/13/16, at 1:37 p.m. NA-B stated R52 received a shower twice a week and was unaware R52 preferred a bath and not a shower. On 4/13/16, at 2:44 p.m. registered nurse (RN)-A stated she was under the impression R52 had preferred showers. RN-A confirmed R52's care plan had indicated it was very important for R52	F 282	planning of resident choice by May 6, 2016. This audit will be completed monthly x 3 months for all residents. Audit findings will be shared at monthly QAPI meetings x 3 months and also reported to Medical Executive Committee on a quarterly basis for that 3 month period.	

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F 282	Continued From page 5	F 282		

to have a tub bath. RN-A stated residents were asked quarterly with care conferences about bathing preference and was unaware R52 did not want a shower.

R54's care plan, dated 3/21/16 identified R54 had weakness and decreased functional status. R54's care plan goal was to receive the assistance she needed to perform ADLs. The care plan listed various interventions which included R54 needed assistance of staff with personal hygiene, trim file nails as needed and to trim R54's facial whiskers with scissors as needed.

R54's nursing care grid dated 4/12/16 listed various grooming interventions which included to assist with hair, and nail care. However, the grid lacked direction for trim of facial whiskers with scissors as needed.

On 4/11/16, at 6:12 p.m. R54 was observed seated in a chair, with several other residents present, in the community dining room during the evening meal. R54 had thick gray facial hair which extended from both sides of her lip line all the way down to below her chin to her throat/neck. R54 had many gray hairs on her upper lip with several long, black, coarse straight hairs that protruded from both corners of her mouth. R54 also had 2 very long black, course straight hairs that stuck out from her right lower cheek. R54's finger nails were painted neatly, her clothes were in new-condition and stylish, and her hair was styled.

On 4/12/16, at 3:30 p.m. R54 was seated in a chair in her room having her finger nails painted by staff, her clothes were in new-condition and

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F 282	Continued From page 6	F 282		

stylish, and her hair was styled. The long, coarse facial hair remained on R54's upper lip, cheek and throat area.

On 4/13/16, at 12:13 p.m. R54 was seated in the community dining room with many other residents, during the noon meal, and again was observed to have thick gray facial hair extending from both sides of her lip line all the way down to her chin to her throat/neck. R54 had many gray hairs on her upper lip with several long, black, coarse straight hairs that protruded from each corner of her mouth. R54 also had 2 very long black, course straight hairs which stuck out from her right lower cheek.

On 4/13/16, at 1:07 p.m. licensed practical nurse (LPN-A) stated the nursing assistant's (NAs) were responsible to check female residents for facial hair every morning, and any facial hair was to be removed before residents came out of their room for breakfast. She stated she would expect residents to be offered facial hair removal every morning, and as they needed it. She confirmed R54's care plan and nursing care grid and confirmed the nursing care grid did not include shaving for R54.

On 4/13/16, at 2:49 p.m. NA-C stated she had never removed facial hair from any female resident in the facility. She confirmed facial hair should be removed every morning and as needed and stated the usual facility practice if facial hair on a woman was present, to offer to remove it as part of their morning cares.

On 4/13/16, 2:52 p.m. NA-D stated the usual facility practice was if nursing assistants noticed facial hair on any resident, was to remove it

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F 282	Continued From page 7 during morning or night-time cares. She indicated she was not aware if R54 required facial hair removal. On 4/14/16, at 8:22 a.m. Clinical Manager, (CM-A) stated the NAs were responsible to check residents for facial hair everyday with morning cares. CM-A confirmed R54's care plan, and nursing care grid. She confirmed R54's facial hair, and stated she knew R54 had some "wild, crazy hairs" before and R54 had wanted the facial hair removed. She confirmed R54 liked being well groomed, got her nails painted routinely, and went to the beauty shop every week.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure assistance was provided with grooming for 1 of 3 residents (R54) who were dependent on staff for assistance with activities of daily living (ADL). Findings include: R54's quarterly Minimum Data Set (MDS) dated 3/10/16 identified R54 had diagnoses which included dementia, depression and heart failure. The MDS identified R54 had severe cognitive	F 312	It is the policy of Sylvan Court to assure all residents are properly groomed which includes removal of facial hair unless resident refuses removal of same. Daily grooming tasks are to be described on the resident□s care plan and grid sheet to frontline staff. Resident # 54 was assisted to remove facial hair on afternoon of 4/21/16. Grid sheet and care plan were updated to include specific plan to remove facial hair weekly and as needed for this resident.	5/16/16

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F 312	Continued From page 8 impairment, and required extensive assistance with personal hygiene, shaving and all activities of daily living (ADLs). R54's care plan, dated 3/21/16 identified R54 had weakness and decreased functional status. R54's care plan goal was to receive the assistance she needed to perform ADLs. The care plan listed various interventions which included R54 needed assistance of staff with personal hygiene, trim file nails as needed and to trim R54's facial whiskers with scissors as needed. R54's nursing care grid dated 4/12/16 listed various grooming interventions which included to assist with hair, and nail care. However, the grid lacked direction for trim of facial whiskers with scissors as needed. On 4/11/16, at 6:12 p.m. R54 was observed seated in a chair, with several other residents present, in the community dining room during the evening meal. R54 had thick gray facial hair which extended from both sides of her lip line all the way down to below her chin to her throat/neck. R54 had many gray hairs on her upper lip with several long, black, coarse straight hairs that protruded from both corners of her mouth. R54 also had 2 very long black, course straight hairs that stuck out from her right lower cheek. R54's finger nails were painted neatly, her clothes were in new-condition and stylish, and her hair was styled. On 4/12/16, at 3:30 p.m. R54 was seated in a chair in her room having her finger nails painted by staff, her clothes were in new-condition and stylish, and her hair was styled. The long, coarse facial hair remained on R54's upper lip, cheek	F 312	All residents were checked for needing removal of facial hair on 4/22/16. Care plans and grid sheets will be updated by 4/28/16 to address removal of female facial hair weekly and as needed; men to be shaved daily. Residents who do not agree with this plan will have specific plans written for their preference. Policy regarding resident personal grooming will be updated by 5/6/16 to be specific to each grooming task. Staff education on resident grooming/shaving process and policy update will be completed by May 6, 2016. DON will develop audit tool regarding facial grooming by 5/16/16. This audit will be completed monthly x 3 months for all residents. Audit findings will be shared at monthly QAPI meetings x 3 months and also reported to Medical Executive Committee on a quarterly basis for that 3 month period.	

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F 312	Continued From page 9	F 312		

and throat area.

On 4/13/16, at 12:13 p.m. R54 was seated in the community dining room with many other residents, during the noon meal, and again was observed to have thick gray facial hair extending from both sides of her lip line all the way down to her chin to her throat/neck. R54 had many gray hairs on her upper lip with several long, black, coarse straight hairs that protruded from each corner of her mouth. R54 also had 2 very long black, course straight hairs which stuck out from her right lower cheek.

On 4/13/16, at 1:07 p.m. licensed practical nurse (LPN-A) stated the nursing assistant's (NAs) were responsible to check female residents for facial hair every morning, and any facial hair was to be removed before residents came out of their room for breakfast. She stated she would expect residents to be offered facial hair removal every morning, and as they needed it. She confirmed R54's care plan and nursing care grid and confirmed the nursing care grid did not include shaving for R54.

On 4/13/16, at 2:49 p.m. NA-C stated she had never removed facial hair from any female resident in the facility. She confirmed facial hair should be removed every morning and as needed and stated the usual facility practice if facial hair on a woman was present, to offer to remove it as part of their morning cares.

On 4/13/16, 2:52 p.m. NA-D stated the usual facility practice was if nursing assistants noticed facial hair on any resident, was to remove it during morning or night-time cares. She indicated she was not aware if R54 required facial hair

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F 312	Continued From page 10 removal. On 4/14/16, at 8:22 a.m. Clinical Manager, (CM-A) stated the NAs were responsible to check residents for facial hair everyday with morning cares. CM-A confirmed R54's care plan, and nursing care grid. She confirmed R54's facial hair, and stated she knew R54 had some "wild, crazy hairs" before and R54 had wanted the facial hair removed. She confirmed R54 liked being well groomed, got her nails painted routinely, and went to the beauty shop every week. Review of the facility policy, Activities of Daily Living (ADL), revised 11/15, identified the purpose of the policy was to provide assistance to residents as necessary and improve their quality of life. The policy included directions for assisting residents with various ADLs which included upper and lower body dressing, and use of assistive devices such as a leg brace. However, the policy did not include directions for grooming for female residents and facial hair removal.	F 312		

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K 000	INITIAL COMMENTS Fire Safety: THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department Of Public Safety, State Fire Marshal Division. At the time of this survey, Sanford Canby Medical Center - Sylvan Court was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/02/2016

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

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SYLVAN COURT	**112 ST OLAF AVENUE SOUTH** **CANBY, MN 56220**

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

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	245433	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/13/2016**

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K 000	Continued From page 2 notification. The facility has a capacity of 58 beds and had a census of 42 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 5 corridor doors according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 23 of the 42 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the Facility tour between 8:15 am to 12:00 pm	K 018	The corridor doors on rooms 101, 143 and 230 were adjusted to fit tightly in the frame by adjusting the hinges and installing smaller latch plates to ensure proper closure. All other corridor doors were audited and adjusted as needed. The over-the-door pulley apparatus was removed from the corridor of room 210. All staff and related departments were reminded not to use over-the-door hooks on corridor doors. No other corridor doors were affected. A latching device was installed on the 2nd	4/21/16

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K 018	Continued From page 3 on 04/13/2016 observations and staff interview revealed deficient conditions on the following corridor doors: 1. Rooms 101, 143 and 230 do not fit tightly in the frame. 2. Room 210 was obstructed from closing. 3. The 2nd floor east corridor storage doors lack a latching device. This deficient condition was verified by the Director of Plant Operations..	K 018	floor corridor door to a storage closet. The Plant Operations Manager was responsible for correction and will assure continuing compliance.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain smoke barrier walls in accordance with NFPA 101-2000 edition, Sections 19.3.7.1, 19.3.7.3, 8.3.2, and 8.3.6. This deficient practice could allow the products of combustion spread throughout the facility in the event of a fire which could affect 23 of the 42 residents as well as an undetermined number of staff and visitors. Findings include: On the Facility tour between 8:15 am to 12:00 pm on 04/13/2016 observations and staff interview revealed penetrations above the ceiling in two smoke barriers. One located on the second floor near room 241 and one located on the first floor	K 025	The smoke barrier wall penetrations near rooms 241 and 111 were sealed with fireproof material. An audit of other areas did not reveal any other unsealed penetrations. The Plant Operations Manager was responsible for correction and will assure continuing compliance.	4/25/16

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K 025	Continued From page 4 near room 111. This deficient condition was verified by the Director of Plant Operations..	K 025		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain a means of egress in accordance with the egress requirements of NFPA 101 Life Safety Code (00) section 7.1.10.1. This decficient practice could affect the safe and efficient exiting of an undetermined amount of staff and visitors Findings include: On the Facility tour between 8:15 am to 12:00 pm on 04/13/2016 observations and staff interview revealed a corridor on the lower level near the maintenance shop was being used for storage. This deficient condition was verified by the Director of Plant Operations..	K 038	Items being stored in lower level hallway have been removed. The Plant Operations Manager was responsible for correction and will assure continuing compliance.	4/29/16
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00),	K 062	The sprinkler head with paint on it was replaced. Regular environmental rounds have not identified any other compromised sprinkler heads.	4/29/16

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K 062	Continued From page 5 Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect, an undetermined amount of staff and visitors. Findings include: On the Facility tour between 8:15 am to 12:00 pm on 04/13/2016 observations and staff interview revealed a sprinkler head in the lower level hazard waste storage room that has paint on a sprinkler head. This deficient condition was verified by the Director of Plant Operations..	K 062	The Plant Operations Manager was responsible for correction and will assure continuing compliance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 42 residents, staff, and visitors. Findings include: On the Facility tour between 8:15 am to 12:00 pm on 04/13/2016 record review and staff interview revealed the generator cool down has not been	K 144	A column for cool down was added to the monthly generator log. Staff were instructed to make entry for cool down. The generator has a timer set for an automatic 5 minute cool down. The Plant Operations Manager was responsible for correction and will assure continuing compliance.	4/19/16

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K 144	Continued From page 6 recorded on the monthly log. This deficient condition was verified by the Director of Plant Operations.	K 144		