DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2025

Administrator
Sylvan Court
112 St Olaf Avenue South
Canby, MN 56220

Re: Reinspection Results
Event ID: R9Q312

Dear Administrator:

On March 14, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 13, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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March 19, 2025

Administrator
Sylvan Court
112 St Olaf Avenue South
Canby, MN 56220

RE: CCN: 245433
Cycle Start Date: February 13, 2025

Dear Administrator:

On March 14, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
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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 _____	02/13/2025

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
E 000	Initial Comments On 2/10/25 through 2/13/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		

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

Electronically Signed | 03/11/2025

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

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F 000	INITIAL COMMENTS On 2/10/25 through 2/13/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54337241C (MN103794) and H54337242C (MN105677). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were coded accurately on their Minimum Data Set (MDS) assessment for 1 of 5 residents (R43) reviewed for medications.	F 641	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	2/13/25

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

Electronically Signed | 03/11/2025

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

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F 641	Continued From page 1 Findings include: R43's 1/22/25, admission MDS admission assessment identified he had a diagnosis of diabetes. R43 was noted to have received one injection of insulin during the look back period. R43's current, physician orders identified no insulin was ordered. The physician orders did include a once weekly dose of Ozempic 0.5 milligrams (mg) injection (a non-insulin medication used to improve blood sugar control). Review of the 11/19/24, RxList, Ozempic Drug Summary, located at https://www.rxlist.com/ozempic-drug.htm, identified Ozempic Injection is a glucagon-like peptide 1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Review of the October 2024, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Section N identified on question 0350 A and B, only insulin should be coded here. Interview on 2/13/25 at 8:03 a.m., and later RAI manual review , with the MDS coordinator identified she understood if Ozempic was used to treat diabetes, it could be coded as an insulin injection on the MDS. She later reviewed the RAI manual and confirmed the Ozempic injection should not have been coded as insulin. A policy related to accuracy of assessments was not provided by end of survey.	F 641	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. F641 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The resident identified who received the GLP-1 medication Ozempic and had it coded as insulin had a correction made on the MDS on the date of 2.13.25. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All other residents currently residing in the facility who are prescribed or take a GLP-1 medication were reviewed and coded appropriately. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, an immediate review of the GLP-1 medication drug class was completed on 2.11.25 by MDS nurse who codes this information on the MDS,	

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F 641	Continued From page 2	F 641	Information was validated with senior clinical nurse analyst for accuracy. This education will prevent any GLP1 from being coded at N0350A/B. (these will still be coded at N0410 under hypoglycemic) 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, for next 3 months, MDS s that have N0350 A coded as having 1 or more days in the 7 day look back period will be validated that the resident is taking and has received a drug in the class as insulin. If it is found that insulin is not being coded appropriately on the MDS, an appropriate plan will be determined by the DON or designee. This information will be reviewed by the QAPI team for further recommendations. 5.What is the date of completion? 2.13.25	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		3/12/25

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F 812	Continued From page 3 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure frozen food items were safely stored off the floor in 2 of 2 walk in freezers located in the kitchen. This had the potential to affect all 43 residents. Findings include: Observation on 2/10/25 at 10:48 a.m., during the initial kitchen tour with the dietary manager (DM) present identified they had 2 walk-in freezers. Upon entering the 1st walk-in, there were multiple boxes of frozen food including sweet potato fries, corn bread, Swedish meatballs, cheese tortellini, potato cubes, breaded chicken, and chili observed on the floor under the bottom shelf. Observation of the 2nd walk-in freezer identified frozen fruit smoothies, enchiladas, assorted pies, queso triangles, slider buns, hoagie buns, and muffin batter stored on the floor. Interview on 2/10/25 at 11:08 a.m., with the DM identified she was aware they were not supposed to store foods on the floor. The facility had storage issues related to having enough room due to additional diet requirements of residents and had identified they needed more freezer space.	F 812	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. F812 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The nutrition and food services supervisor removed all items that were being stored on the floor from two walk-in freezers on the date of 2.11.25	

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F 812	Continued From page 4 Interview on 2/11/25 at 3:30 p.m., with the administrator identified he was aware of the concerns and thought it may be related to over-ordering. He was made aware of the concern after the DM notified him, and the freezer had been re-organized to provide room for all items to be stored on the shelves and off the floor. He agreed food should not be stored on the floor. Review of the facilities undated Food Storage Standards policy identified that all foods were to be stored on a shelf at least 6 inches above the floor.	F 812	2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents had the same impact, and this was not isolated to one resident. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, staff education was completed to ensure nutrition and food services staff will not store items on the floor in any areas whether cold or dry storage. Staff education will be provided in person at their monthly staff meeting on 3.12.25 and competency will be validated via a quiz. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, nutrition food services supervisor or designee will complete audits 1x a week for 4 weeks in freezers to assure all items are stored correctly. This audit will be completed 2x a month for 2 months. Results will be reviewed at the QAPI committee meeting for recommendations. 5.What is the date of completion? 3.12.25	

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	00722	A. BUILDING: _____ B. WING _____	02/13/2025

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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 2/10/25 through 2/13/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H54337241C (MN103794) and H54337242C (MN105677. NO licensing orders were issued. 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 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

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2 000	Continued From page 2 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.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential;	2 540		2/13/25

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2 540	Continued From page 3 L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were coded accurately on their Minimum Data Set (MDS) assessment for 1 of 5 residents (R43) reviewed for medications. Findings include: R43's 1/22/25, admission MDS admission assessment identified he had a diagnosis of diabetes. R43 was noted to have received one injection of insulin during the look back period. R43's current, physician orders identified no insulin was ordered. The physician orders did include a once weekly dose of Ozempic 0.5 milligrams (mg) injection (a non-insulin medication used to improve blood sugar control). Review of the 11/19/24, RxList, Ozempic Drug Summary, located at https://www.rxlist.com/ozempic-drug.htm, identified Ozempic Injection is a glucagon-like peptide 1 (GLP-1) receptor agonist indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Review of the October 2024, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Section N identified on question 0350 A and B, only insulin should be coded here. Interview on 2/13/25 at 8:03 a.m., and later RAI	2 540	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. F641 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The resident identified who received the GLP-1 medication Ozempic and had it coded as insulin had a correction made on the MDS on the date of 2.13.25. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All other residents currently residing in the facility who are prescribed or take a GLP-1 medication were reviewed and coded appropriately.	

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2 540	Continued From page 4 manual review , with the MDS coordinator identified she understood if Ozempic was used to treat diabetes, it could be coded as an insulin injection on the MDS. She later reviewed the RAI manual and confirmed the Ozempic injection should not have been coded as insulin. A policy related to accuracy of assessments was not provided by end of survey. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540	3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, an immediate review of the GLP-1 medication drug class was completed on 2.11.25 by MDS nurse who codes this information on the MDS, Information was validated with senior clinical nurse analyst for accuracy. This education will prevent any GLP1 from being coded at N0350A/B. (these will still be coded at N0410 under hypoglycemic) 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, for next 3 months, MDS s that have N0350 A coded as having 1 or more days in the 7 day look back period will be validated that the resident is taking and has received a drug in the class as insulin. If it is found that insulin is not being coded appropriately on the MDS, an appropriate plan will be determined by the DON or designee. This information will be reviewed by the QAPI team for further recommendations. 5.What is the date of completion? 2.13.25	
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food	21095		3/12/25

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21095	Continued From page 5 Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure frozen food items were safely stored off the floor in 2 of 2 walk in freezers located in the kitchen. This had the potential to affect all 43 residents. Findings include: Observation on 2/10/25 at 10:48 a.m., during the initial kitchen tour with the dietary manager (DM) present identified they had 2 walk-in freezers. Upon entering the 1st walk-in, there were multiple boxes of frozen food including sweet potato fries, corn bread, Swedish meatballs, cheese tortellini, potato cubes, breaded chicken, and chili observed on the floor under the bottom shelf. Observation of the 2nd walk-in freezer identified frozen fruit smoothies, enchiladas, assorted pies, queso triangles, slider buns, hoagie buns, and muffin batter stored on the floor.	21095	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. F812 1.What corrective action will be accomplished for those residents found to	

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 _____	02/13/2025

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) COMPLETE DATE
21095	Continued From page 6 Interview on 2/10/25 at 11:08 a.m., with the DM identified she was aware they were not supposed to store foods on the floor. The facility had storage issues related to having enough room due to additional diet requirements of residents and had identified they needed more freezer space. Interview on 2/11/25 at 3:30 p.m., with the administrator identified he was aware of the concerns and thought it may be related to over-ordering. He was made aware of the concern after the DM notified him, and the freezer had been re-organized to provide room for all items to be stored on the shelves and off the floor. He agreed food should not be stored on the floor. Review of the facilities undated Food Storage Standards policy identified that all foods were to be stored on a shelf at least 6 inches above the floor. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate security and sanitation of food items and or equipment in the kitchen and dining areas. The facility should also ensure appropriate storage of food occurs. The facility could update or create policies and procedures and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits and report audit findings to the Quality Assurance Performance Improvement (QAPI) for further recommendations or to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21095	have been affected by the deficient practice? The nutrition and food services supervisor removed all items that were being stored on the floor from two walk-in freezers on the date of 2.11.25 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents had the same impact, and this was not isolated to one resident. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, staff education was completed to ensure nutrition and food services staff will not store items on the floor in any areas whether cold or dry storage. Staff education will be provided in person at their monthly staff meeting on 3.12.25 and competency will be validated via a quiz. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance is maintained, nutrition food services supervisor or designee will complete audits 1x a week for 4 weeks in freezers to assure all items are stored correctly. This audit will be completed 2x a month for 2 months. Results will be reviewed at the QAPI	

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21095	Continued From page 7 (21) days.	21095	committee meeting for recommendations. 5.What is the date of completion? 3.12.25	

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	245433	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2025**

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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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/11/2025. At the time of this survey, Sylvan Court was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. SYLVAN COURT is a 2-story building with a 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.	K 000		

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K 000	Continued From page 2 Because the original building and addition meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 43 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at	K 222		3/13/25

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K 222	Continued From page 3 all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on	K 222		

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K 222	Continued From page 4 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install door locks per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1, 7.2.1, 7.2.1.5.1, and 7.2.1.5.3. This deficient finding could have an isolated impact on the occupants within the facility. Findings include: On 02/11/2025 between 9:45 AM and 12:00 PM it was revealed by observation that the door to the med room had a hasp type hinge latch and was padlocked shut. An interview with the Administrator and the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 222	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The plant operations supervisor and environmental services supervisor educated staff to have two staff present at all times when entering the hazardous medication room to assure safe egress. One staff members responsibility will be to remain outside of the room and monitor the latch device to assure the staff member entering the room will have adequate egress.	

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K 222	Continued From page 5	K 222	The staff who have keyed access to this room were educated on this process via a read and sign on or before the date of 3.13.25. Additionally, plant operations supervisor contacted a construction project manager on the date of 3.5.25 who will be making a site visit on 3.12.25 and will provide recommendations to modify and remove the current door to meet the regulatory requirements of NFPA 101. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? Residents do not enter this area of the building, so no impact is associated. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure compliance is maintained, a timely permanent change in the door to this room will be made as soon as contractors and materials arrive. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? All other doors in the facility are compliant with NFPA 101. 5.What is the date of completion? 3/13/2025	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		2/20/25

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K 353	Continued From page 6 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(5), and 5.2.2.2. This deficient finding could have a isolated impact on residents within the facility. Findings include: On 02/11/2025 between 9:45 AM and 12:00 PM, it was revealed by observation that a IT cable was zip tied to the sprinkler pipe located in the 200 wing on the 2nd floor.	K 353	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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K 353	Continued From page 7 An interview with the Administrator and the Maintenance Supervisor verified this deficient finding at the time of discovery.	K 353	1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 2.13.25, plant operations staff removed zip tie on the sprinkler piping identified on the survey. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? On 2.13.25, sprinkler piping in remainder of the building was observed and inspected for any other findings that would be in non-compliance. No other areas were observed. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Plant operations team was educated on the need to complete visual inspection of fire protection system sprinkler piping following contractor and vendor work to assure that no disruptions have occurred. This education was completed via read and sign on or before 2.20.25 to all plant operations staff. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Plant operations supervisor or designee is made aware when contractors are completing work in the building and will be responsible to ensure contractors are not to tamper with fire protection system and will assure a visual inspection is	

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K 353	Continued From page 8	K 353	completed upon conclusion of their work. 5.What is the date of completion? 2.20.25	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/11/2025 between 9:45 AM and 12:00 PM, it was revealed by observation that there were unsealed penetrations in the smoke barrier located on Oak at the Willow and Maple barrier. An interview with the Administrator and	K 372	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section	2/20/25

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K 372	Continued From page 9 Maintenance Supervisor verified this deficient finding at the time of discovery.	K 372	7305 of the State Operations Manual. 1.What corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 2.13.25, fire caulk was applied to smoke penetrations identified on the survey. 2.How will other residents, having the potential to be affected by the same deficient practice, be identified? On 2.13.25, smoke penetration compartments in remainder of the building was observed and inspected for any other findings that would be in non-compliance. No other areas were observed. 3.What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Plant operations team was educated on the need to complete visual inspection of smoke compartments following contractor and vendor work to assure that no disruptions have occurred. This education was completed via read and sign on or before 2.20.25 to all plant operations staff. 4.How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Plant operations supervisor or designee is made aware when contractors are completing work in the building and will be responsible to ensure contractors are not	

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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
K 372	Continued From page 10	K 372	to tamper with fire protection system and will assure a visual inspection is completed upon conclusion of their work. 5.What is the date of completion? 2.20.25	