REVISED

Electronically Delivered

November 8, 2023

Licensee
Sanford Health Sylvan Place
212 St. Olaf Avenue South
Canby, MN 56220

RE: Project Number(s) SL23511015

Dear Licensee:

Please Note: The letter you previously received dated September 22, 2023, has been revised. Specifically, the scope and severity (S/L) was reduced from an F to a C. As a result, the fine for tag 0110, has been rescinded.

The Minnesota Department of Health (MDH) completed a survey on August 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of

correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
HRD 3A, 3rd Floor
P.O. Box 64900
625 Robert Street North
St. Paul, MN 55155

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

Electronically Delivered

September 22, 2023

Licensee
Sanford Health Sylvan Place
212 St. Olaf Avenue South
Canby, MN 56220

RE: Project Number(s) SL23511015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required = $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. §

626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23511	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH SYLVAN PLACE	212 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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. *******REVISED******* Revisions were made to tag 0110. Specifically the Scope and Level (S/L) was reduced to a C. Previously tag 0110 was cited at a S/L of F. INITIAL COMMENTS: SL23511015 On August 28, 2023, through August 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 17 active residents; all of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 28, 2023, at 12:13 p.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 13, 2023; however, LALD-A's license failed to identify him as the Director of Record for the licensee. On August 28, 2023, at 12:53 p.m. LALD-A verified via email he was not listed as the director of record, and he had reached out to BELTSS to correct it. On August 28, 2023, at 12:35 p.m. the evaluator emailed a BELTSS representative to clarify LALD-A's status as director of record for the	0 110		

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0 110	Continued From page 2 facility. At 1:30 p.m., the BELTSS representative responded LALD-A was not listed as Director of Record for this licensee and LALD-A needed to update Director of Record for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 17 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 480		

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0 480	Continued From page 3 Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 4 Based on observation, interview, and record review, the licensee failed to post an emergency plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Upon entrance to the facility on August 28, 2023, at 10:00 a.m., the evaluator observed no signage posted or information regarding the licensee's emergency plan. On August 28, 2023, at 12:30 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the emergency preparedness binder was located in their locked office. Staff had access to the binder; however, residents and visitors did not have access to the emergency preparedness plan. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 5 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. The facility plan indicated to use RACE acronym but did not provide complete actions for employees	0 810		

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0 810	Continued From page 6 and residents to take in the event of a fire or similar emergency. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on August 30, 2023, at approximately 11:30 a.m. with Licensed Assisted Living Director (LALD)-A, Safety Coordinator (SC)-D, Lead Maintenance Mechanic (LMM)-E and Supervisor Plant Operations (SPO)-F. on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee and resident actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review did not show specific employee actions to be taken in the event of a fire or similar emergency. Record review did not show specific fire protection procedures necessary for residents.	0 810		

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0 810	Continued From page 7 Record review did not have complete information that shows procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview, LALD-A, SC-D, LMM-E, and SPO-F verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in	01290		

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01290	Continued From page 8 affiliation with the assisted living license for three of three employees (unlicensed personnel (ULP-C), licensed assisted living director (LALD-A), and registered nurse/licensed assisted living director (RN/LALD)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on June 10, 1994, and began providing direct care services under the Assisted Living (ALF) license on August 1, 2021. On August 29, 2023, from 6:49 a.m. to 7:30 a.m. the surveyor observed ULP-C completing the following tasks: - administer medications to R5; - administer medications and apply compression stockings to R3; and - administer medications and apply compression stockings to R2. ULP-C's employee record contained a background study dated May 1, 1996. ULP-C's record lacked evidence the licensee affiliated a background study for the ALF license. LALD-A LALD-A was hired on May 16, 2006, and began providing services under the ALF license on	01290		

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01290	Continued From page 9 August 1, 2021. LALD-A was observed throughout the survey process in the common areas interacting with residents of the assisted living. RN/LALD-B RN/LALD-B was hired on May 15, 2007, and began providing services under the ALF license on August 1, 2021. RN/LALD-B was observed throughout the survey process in the common areas interacting with residents of the assisted living. On August 30, 2023, at 8:22 a.m. LALD-A stated many of the staff were not affiliated with the correct health facility identification (HFID). He was aware of the requirement but was unaware the human resources (HR) department had not affiliated the staff to the correct HFID. The HR department had reviewed NETStudy, after it was requested by the surveyor, and affiliated all staff working for the ALF on August 29, 2023. On August 30, 2023, at 7:27 a.m. received via email a NETStudy list of employees and their status. The list included 20 employees who had prior background studies but were affiliated to the ALF's HFID on August 29, 2023, which included ULP-C, LALD-A, and RN/LALD-B. The licensees State-Specific Senior Living Information- Minnesota policy dated October 13, 2022, identified "The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. Records must be maintained for at least three years after staff/volunteer/ contractor leaves ALF	01290		

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01290	Continued From page 10 or ALF ceases operation", which included "vi. Documentation of background study" No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reassessment and monitoring of medication management services was completed when there was a change in services for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01710		

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01710	Continued From page 11 On August 29, 2023, at 7:21 a.m. the surveyor observed unlicensed personnel (ULP)-C administer medications to R2. R2's Service Agreement dated August 25, 2022, identified R2 received "Medications: assistance with medication passes 1- 3 times daily". R2's Nursing Assessment and Level of Care Evaluation dated August 2, 2023, identified R2 received medication set up with cues from staff after set up. R2's August 2023, medication administration record (MAR) identified staff began administering medications on August 10, 2023. On August 30, 2023, at 1:20 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the medication management assessment and plan should have been updated to medication administration when the services changed from medication set up to medication administration. The licensee's undated, Medication Management Services policy identified "The RN is responsible for the implementation of our agency's medication management policies and procedures. The RN will develop an individualized medication management plan for each client. The RN will assure that unlicensed personnel are trained, competent and oriented to the client whenever unlicensed personnel are to perform medication management services for the client." The licensee's undated, Monitoring of Clients and Their Services policy identified "During the monitoring visit and reassessment of the client, the RN will:"	01710		

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01710	Continued From page 12 -"If the agency is responsible for medication management for the client, the RN will determine whether the client's medications are effective, whether the client is having any side effects, whether there are any contraindications of the medications or whether there are any concerns about diversion of medications or other concerns. If changes in the client's needs are identified during the monitoring visit and reassessment, the RN will update the client's assessment and will determine whether changes are needed in the service plan. If changes are needed in the client's service plan, the RN will discuss the changes with the client and/or the client's". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	01730		

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01730	Continued From page 13 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01730		

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01730	Continued From page 14 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 On August 29, 2023, at 7:21 a.m. the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R2. R2's Service Agreement dated August 25, 2022, identified R2 received "Medications: assistance with medication passes 1-3 times daily". R2's Nursing Assessment and Level of Care Evaluation dated August 2, 2023, identified R2 received medication set-up with cues from staff after set up. R2's record failed to have the following medication management plan required content: - a statement identifying R2 received medication administration services; and - identification of medication management tasks that may be delegated to unlicensed personnel. R2's August 2023, medication administration record (MAR) identified staff began administering medications on August 10, 2023. R3 On August 29, 2023, at 7:00 a.m. the surveyor observed ULP-C administer oral medications to R3. R3's Service Agreement dated August 26, 2022, identified R3 received medication assistance/cues one to three times per day.	01730		

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01730	Continued From page 15 R3's Nursing Assessment and Level of Care Evaluation dated June 30, 2023, identified R3 received medication administration. R3's record failed to have the following medication management plan required content: - identification of medication management tasks that may be delegated to unlicensed personnel. On August 30, 2023, at 1:20 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the medication management assessment and plan for R2 should have been updated to medication administration when the services changed from medication set-up to medication administration. At 2:42 p.m., RN/LALD-B further stated the medication management assessment and plan failed to identify the medication management tasks that could be delegated to unlicensed personnel. The licensee's undated, Medication Management Services policy identified "The RN is responsible for the implementation of our agency's medication management policies and procedures. The RN will develop an individualized medication management plan for each client. The RN will assure that unlicensed personnel are trained, competent and oriented to the client whenever unlicensed personnel are to perform medication management services for the client." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01770	Continued From page 16	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed for two of two residents (R2 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 7:21 a.m. the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R2. R2's Service Agreement dated August 25, 2022, identified R2 received "Medications: assistance with medication passes 1- 3 times daily". R2's Nursing Assessment and Level of Care Evaluation dated August 2, 2023, identified R2 received medication set-up with cues from staff	01770		

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01770	Continued From page 17 after set-up. R2's August 2023, medication administration record (MAR) identified staff began administering medications on August 10, 2023. On the bottom of the page there was a box titled "meds filled" with the dates of August 1, 2023, and August 7, 2023, and the registered nurse (RN) initials. R2's untitled document contained columns titled start date, medication name/dosage, times, route, and special instructions. The rows contained the medications R2 was taking and the information for each medication. In the space to the left of the table were the dates "August 1", and "August 8," and a column of dots under the date next to each row. R4 R4's Service Agreement dated August 29, 2022, identified R4 received medication set-up service. R4's Nursing Assessment and Level of Care Evaluation dated July 26, 2023, identified R4 received pill box set up and cues. R4's August 2023, MAR identified staff were to give cues for medications and other tasks the unlicensed staff were to complete. There were no medications identified on the MAR. On the bottom of the page there was a box titled "meds filled" with the dates of August 1, 2023, and August 8, 2023, August 15, 2023, August 22, 2023, August 29, 2023, and the registered nurse (RN) initials. R4's untitled document contained columns titled start date, medication name/dosage, times, route, and special instructions. The rows contained the medications R4 was taking and the information	01770		

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01770	Continued From page 18 for each medication. In the space to the left of the table were the dates "August 1, August 8, August 15, August 22," and a column of dots under the date next to each row. The documentation for R2 and R4 failed to identify the dates of medication setup name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. On August 25, 2023, at 1:23 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the date and dots on the untitled document were how she documented medication set up along with the date on the bottom left corner of the MAR. RN/LALD-B was unaware of the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	01970		

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01970	Continued From page 19 Based on observation, interview, and record review, the licensee failed to ensure a written prescriber's order for a treatment was obtained for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 29, 2023, at 7:21 a.m. the surveyor observed unlicensed personnel (ULP)-C put TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation and reduce swelling) on R2. R2's Care Plan signed February 17, 2023, identified R2 received assistance with TED stockings. R2's Nursing Assessment and Level of Care Evaluation dated August 2, 2023, identified R2 required assistance with TED stockings. R2's signed physician orders dated June 22, 2023, failed to identify TED stockings. R2's medical record lacked an order for TED stockings. On August 30, 2023, at 1:08 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the TED stockings order must have been a recommendation from therapy	01970		

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01970	Continued From page 20 and an order from the medical provider was not obtained. The licensee's Treatment And Therapy Management Services - Minnesota policy dated May 11, 2023, identified "Requesting and receiving orders or prescriptions for treatments or therapies: A. The RN is responsible for assuring that current, authorized healthcare provider orders for treatments and therapies administered by assisted living employees are kept and maintained in the resident medical record, that changes in orders are addressed in the resident's service plan and service agreement and that orders are properly communicated to employees. B. An order for treatment or therapy must be dated, signed by the healthcare provider and current and consistent with the resident's nursing assessment(s). C. Treatment and therapy orders must be renewed by the healthcare provider at least every 12 months." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23511015 On August 28, 2023, through August 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 17 active residents; all of whom received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 28, 2023, at 12:13 p.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 13, 2023; however, LALD-A's license failed to identify him as the Director of Record for the licensee. On August 28, 2023, at 12:53 p.m. LALD-A verified via email he was not listed as the director of record, and he had reached out to BELTSS to correct it. On August 28, 2023, at 12:35 p.m. the evaluator emailed a BELTSS representative to clarify LALD-A's status as director of record for the	0 110		

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0 110	Continued From page 2 facility. At 1:30 p.m., the BELTSS representative responded LALD-A was not listed as Director of Record for this licensee and LALD-A needed to update Director of Record for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 17 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	0 480		

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	23511	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH SYLVAN PLACE	212 ST. OLAF AVENUE SOUTH CANBY, MN 56220

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0 480	Continued From page 3 Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 4 Based on observation, interview, and record review, the licensee failed to post an emergency plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Upon entrance to the facility on August 28, 2023, at 10:00 a.m., the evaluator observed no signage posted or information regarding the licensee's emergency plan. On August 28, 2023, at 12:30 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the emergency preparedness binder was located in their locked office. Staff had access to the binder; however, residents and visitors did not have access to the emergency preparedness plan. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 5 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. The facility plan indicated to use RACE acronym but did not provide complete actions for employees	0 810		

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0 810	Continued From page 6 and residents to take in the event of a fire or similar emergency. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on August 30, 2023, at approximately 11:30 a.m. with Licensed Assisted Living Director (LALD)-A, Safety Coordinator (SC)-D, Lead Maintenance Mechanic (LMM)-E and Supervisor Plant Operations (SPO)-F. on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee and resident actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review did not show specific employee actions to be taken in the event of a fire or similar emergency. Record review did not show specific fire protection procedures necessary for residents.	0 810		

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0 810	Continued From page 7 Record review did not have complete information that shows procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview, LALD-A, SC-D, LMM-E, and SPO-F verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in	01290		

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01290	Continued From page 8 affiliation with the assisted living license for three of three employees (unlicensed personnel (ULP-C), licensed assisted living director (LALD-A), and registered nurse/licensed assisted living director (RN/LALD)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on June 10, 1994, and began providing direct care services under the Assisted Living (ALF) license on August 1, 2021. On August 29, 2023, from 6:49 a.m. to 7:30 a.m. the surveyor observed ULP-C completing the following tasks: - administer medications to R5; - administer medications and apply compression stockings to R3; and - administer medications and apply compression stockings to R2. ULP-C's employee record contained a background study dated May 1, 1996. ULP-C's record lacked evidence the licensee affiliated a background study for the ALF license. LALD-A LALD-A was hired on May 16, 2006, and began providing services under the ALF license on	01290		

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01290	Continued From page 9 August 1, 2021. LALD-A was observed throughout the survey process in the common areas interacting with residents of the assisted living. RN/LALD-B RN/LALD-B was hired on May 15, 2007, and began providing services under the ALF license on August 1, 2021. RN/LALD-B was observed throughout the survey process in the common areas interacting with residents of the assisted living. On August 30, 2023, at 8:22 a.m. LALD-A stated many of the staff were not affiliated with the correct health facility identification (HFID). He was aware of the requirement but was unaware the human resources (HR) department had not affiliated the staff to the correct HFID. The HR department had reviewed NETStudy, after it was requested by the surveyor, and affiliated all staff working for the ALF on August 29, 2023. On August 30, 2023, at 7:27 a.m. received via email a NETStudy list of employees and their status. The list included 20 employees who had prior background studies but were affiliated to the ALF's HFID on August 29, 2023, which included ULP-C, LALD-A, and RN/LALD-B. The licensees State-Specific Senior Living Information- Minnesota policy dated October 13, 2022, identified "The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. Records must be maintained for at least three years after staff/volunteer/ contractor leaves ALF	01290		

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01290	Continued From page 10 or ALF ceases operation", which included "vi. Documentation of background study" No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reassessment and monitoring of medication management services was completed when there was a change in services for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01710		

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01710	Continued From page 11 On August 29, 2023, at 7:21 a.m. the surveyor observed unlicensed personnel (ULP)-C administer medications to R2. R2's Service Agreement dated August 25, 2022, identified R2 received "Medications: assistance with medication passes 1- 3 times daily". R2's Nursing Assessment and Level of Care Evaluation dated August 2, 2023, identified R2 received medication set up with cues from staff after set up. R2's August 2023, medication administration record (MAR) identified staff began administering medications on August 10, 2023. On August 30, 2023, at 1:20 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the medication management assessment and plan should have been updated to medication administration when the services changed from medication set up to medication administration. The licensee's undated, Medication Management Services policy identified "The RN is responsible for the implementation of our agency's medication management policies and procedures. The RN will develop an individualized medication management plan for each client. The RN will assure that unlicensed personnel are trained, competent and oriented to the client whenever unlicensed personnel are to perform medication management services for the client." The licensee's undated, Monitoring of Clients and Their Services policy identified "During the monitoring visit and reassessment of the client, the RN will:"	01710		

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01710	Continued From page 12 -"If the agency is responsible for medication management for the client, the RN will determine whether the client's medications are effective, whether the client is having any side effects, whether there are any contraindications of the medications or whether there are any concerns about diversion of medications or other concerns. If changes in the client's needs are identified during the monitoring visit and reassessment, the RN will update the client's assessment and will determine whether changes are needed in the service plan. If changes are needed in the client's service plan, the RN will discuss the changes with the client and/or the client's". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	01730		

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01730	Continued From page 13 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all required content for two of two residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01730		

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01730	Continued From page 14 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 On August 29, 2023, at 7:21 a.m. the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R2. R2's Service Agreement dated August 25, 2022, identified R2 received "Medications: assistance with medication passes 1-3 times daily". R2's Nursing Assessment and Level of Care Evaluation dated August 2, 2023, identified R2 received medication set-up with cues from staff after set up. R2's record failed to have the following medication management plan required content: - a statement identifying R2 received medication administration services; and - identification of medication management tasks that may be delegated to unlicensed personnel. R2's August 2023, medication administration record (MAR) identified staff began administering medications on August 10, 2023. R3 On August 29, 2023, at 7:00 a.m. the surveyor observed ULP-C administer oral medications to R3. R3's Service Agreement dated August 26, 2022, identified R3 received medication assistance/cues one to three times per day.	01730		

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01730	Continued From page 15 R3's Nursing Assessment and Level of Care Evaluation dated June 30, 2023, identified R3 received medication administration. R3's record failed to have the following medication management plan required content: - identification of medication management tasks that may be delegated to unlicensed personnel. On August 30, 2023, at 1:20 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the medication management assessment and plan for R2 should have been updated to medication administration when the services changed from medication set-up to medication administration. At 2:42 p.m., RN/LALD-B further stated the medication management assessment and plan failed to identify the medication management tasks that could be delegated to unlicensed personnel. The licensee's undated, Medication Management Services policy identified "The RN is responsible for the implementation of our agency's medication management policies and procedures. The RN will develop an individualized medication management plan for each client. The RN will assure that unlicensed personnel are trained, competent and oriented to the client whenever unlicensed personnel are to perform medication management services for the client." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01770	Continued From page 16	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed for two of two residents (R2 and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, at 7:21 a.m. the surveyor observed unlicensed personnel (ULP)-C administer oral medications to R2. R2's Service Agreement dated August 25, 2022, identified R2 received "Medications: assistance with medication passes 1- 3 times daily". R2's Nursing Assessment and Level of Care Evaluation dated August 2, 2023, identified R2 received medication set-up with cues from staff	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23511	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH SYLVAN PLACE	212 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
01770	Continued From page 17 after set-up. R2's August 2023, medication administration record (MAR) identified staff began administering medications on August 10, 2023. On the bottom of the page there was a box titled "meds filled" with the dates of August 1, 2023, and August 7, 2023, and the registered nurse (RN) initials. R2's untitled document contained columns titled start date, medication name/dosage, times, route, and special instructions. The rows contained the medications R2 was taking and the information for each medication. In the space to the left of the table were the dates "August 1", and "August 8," and a column of dots under the date next to each row. R4 R4's Service Agreement dated August 29, 2022, identified R4 received medication set-up service. R4's Nursing Assessment and Level of Care Evaluation dated July 26, 2023, identified R4 received pill box set up and cues. R4's August 2023, MAR identified staff were to give cues for medications and other tasks the unlicensed staff were to complete. There were no medications identified on the MAR. On the bottom of the page there was a box titled "meds filled" with the dates of August 1, 2023, and August 8, 2023, August 15, 2023, August 22, 2023, August 29, 2023, and the registered nurse (RN) initials. R4's untitled document contained columns titled start date, medication name/dosage, times, route, and special instructions. The rows contained the medications R4 was taking and the information	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23511	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH SYLVAN PLACE	212 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
01770	Continued From page 18 for each medication. In the space to the left of the table were the dates "August 1, August 8, August 15, August 22," and a column of dots under the date next to each row. The documentation for R2 and R4 failed to identify the dates of medication setup name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. On August 25, 2023, at 1:23 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the date and dots on the untitled document were how she documented medication set up along with the date on the bottom left corner of the MAR. RN/LALD-B was unaware of the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by:	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23511	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH SYLVAN PLACE	212 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
01970	Continued From page 19 Based on observation, interview, and record review, the licensee failed to ensure a written prescriber's order for a treatment was obtained for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 29, 2023, at 7:21 a.m. the surveyor observed unlicensed personnel (ULP)-C put TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation and reduce swelling) on R2. R2's Care Plan signed February 17, 2023, identified R2 received assistance with TED stockings. R2's Nursing Assessment and Level of Care Evaluation dated August 2, 2023, identified R2 required assistance with TED stockings. R2's signed physician orders dated June 22, 2023, failed to identify TED stockings. R2's medical record lacked an order for TED stockings. On August 30, 2023, at 1:08 p.m. registered nurse/licensed assisted living director (RN/LALD)-B stated the TED stockings order must have been a recommendation from therapy	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23511	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 20 and an order from the medical provider was not obtained. The licensee's Treatment And Therapy Management Services - Minnesota policy dated May 11, 2023, identified "Requesting and receiving orders or prescriptions for treatments or therapies: A. The RN is responsible for assuring that current, authorized healthcare provider orders for treatments and therapies administered by assisted living employees are kept and maintained in the resident medical record, that changes in orders are addressed in the resident's service plan and service agreement and that orders are properly communicated to employees. B. An order for treatment or therapy must be dated, signed by the healthcare provider and current and consistent with the resident's nursing assessment(s). C. Treatment and therapy orders must be renewed by the healthcare provider at least every 12 months." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

DEPARTMENT OF HEALTH

Type: Full
Date: *08/29/23*
Time: 11:40:00
Report: 1033231174

Food and Beverage Establishment Inspection Report

Location:
Sanford Health Sylvan Place
212 St. Olaf Avenue South
Canby, MN56220
Yellow Medicine County, 87

Establishment Info:
ID #: 0037628
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072237277
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-300 Personal Cleanliness

2-301.14A ***** Priority 1 *****

MN Rule 4626.0075A Food employees must wash their hands before: food preparation activities, including working with exposed food; touching clean equipment and utensils; touching unwrapped single-service and single-use articles.

Employee observed not washing their hands before serving food.
Comply By: 08/29/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Serving kitchen does not have a test kit to measure sanitizing concentration.
Comply By: 09/12/23

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Dishes are stored in the hand sink.
Comply By: 08/29/23

Surface and Equipment Sanitizers

Food and Beverage Establishment Inspection Report

Quaternary Ammonium: = 400PPM at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: Chicken-Hot Line
Violation Issued: No

Process/Item: Hot Holding
Temperature: 140 Degrees Fahrenheit - Location: Macaroni and Cheese-Hot Line
Violation Issued: No

Process/Item: Hot Holding
Temperature: 137 Degrees Fahrenheit - Location: Mashed Potatoes and Gravy-Hot Line
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 32 Degrees Fahrenheit - Location: Cooler
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	2	0

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1033231174 of 08/29/23.

Certified Food Protection Manager: Mary E Keimig

Certification Number: FM23047 Expires: 12/27/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Mary E Keimig

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033231174

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	2	Date	08/29/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:40:00
Legal Authority MN Rules Chapter 4626		Time Out	

Sanford Health Sylvan Place	Address: 212 St. Olaf Avenue South	City/State: Canby, MN	Zip Code: 56220	Telephone: 5072237277
License/Permit #: 0037628	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	IN	OUT		(N/O)	Proper eating, tasting, drinking, or tobacco use		
7	IN	OUT		(N/O)	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	IN	(OUT)		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN	(OUT)			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	(N/A)	N/O	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	(IN)	OUT	N/A	N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

						COS	R
Safe Food and Water							
30	(IN)	OUT	N/A		Pasteurized eggs used where required		
31					Water & ice obtained from an approved source		
32	IN	OUT	(N/A)		Variance obtained for specialized processing methods		
Food Temperature Control							
33					Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	(N/A)	N/O	Plant food properly cooked for hot holding		
35	IN	OUT	(N/A)	N/O	Approved thawing methods used		
36					Thermometers provided & accurate		
Food Identification							
37					Food properly labled; original container		
Prevention of Food Contamination							
38					Insects, rodents, & animals not present		
39					Contamination prevented during food prep, storage & display		
40					Personal cleanliness		
41					Wiping cloths: properly used & stored		
42					Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 09/01/23

Inspector (Signature)