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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2M2Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00501

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245347**

2. STATE VENDOR OR MEDICAID NO. (L2) **009342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **LYNGBLOMSTEN CARE CENTER**
(L4) **1415 ALMOND AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55108**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **8/16/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **237** (L18)

13. Total Certified Beds **237** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___ 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	237			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 08/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **09/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 08/10/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245347

August 19, 2016

Mr. Jeffrey Heinecke, Administrator
Lyngblomsten Care Center
1415 Almond Avenue
Saint Paul, MN 55108

Dear Mr. Heinecke:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 8, 2016 the above facility is certified for:

237 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 237 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 19, 2016

Mr. Jeffrey Heinecke, Administrator
Lyngblomsten Care Center
1415 Almond Avenue
Saint Paul, MN 55108

RE: Project Number S5347029

Dear Mr. Heinecke:

On July 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 29, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 16, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 12, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 29, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 29, 2016, effective August 8, 2016 and therefore remedies outlined in our letter to you dated July 19, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245347 Y1	A. Building B. Wing Y2	8/16/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0279	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	08/08/2016	LSC	08/08/2016	LSC	08/08/2016
ID Prefix F0282	Correction	ID Prefix F0318	Correction	ID Prefix F0328	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(k)	Completed
LSC	08/08/2016	LSC	08/08/2016	LSC	08/08/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/08/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	08/19/2016	18623	8/16/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/29/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245347 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0018	08/08/2016	LSC	K0025	08/08/2016	LSC	K0062	08/08/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0144	08/08/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	8/19/2016	37010	8/12/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/28/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2M2Y

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00501

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245347**

2. STATE VENDOR OR MEDICAID NO. (L2) **009342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **LYNGBLOMSTEN CARE CENTER**
(L4) **1415 ALMOND AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55108**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/29/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **237** (L18)

13.Total Certified Beds **237** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	237			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : 08/02/2016 (L19)
Rebecca Wong, HFE NE II

18. STATE SURVEY AGENCY APPROVAL Date: 08/05/2016 (L20)
Kamala Fiske-Downing, Health Program Representative

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **09/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 08/10/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 19, 2016

Mr. Jeffrey Heinecke, Administrator
Lyngblomsten Care Center
1415 Almond Avenue
Saint Paul, MN 55108

RE: Project Number S5347029, Complaint Numbers H5247078 AND H5247079

Dear Mr. Heinecke:

On June 29, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 29, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5247078 AND H5247079 that were found to be unsubstantiated.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 8, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 29, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 29, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted June 26th through June 29th 2016 and two complaints investigations were also completed at the time of the standard survey. An investigation of complaints H5247079 and H5247078 was completed and were found not to be substantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225		8/8/16

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

Electronically Signed | 07/29/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the administrator and State agency (SA) as required and in accordance with facility policy for 1 of 4 residents (R144) who alleged sexual abuse treatment by staff. Findings include: A vulnerable adult (VA) report dated 6/7/16, indicated "On 6/6/16, around supper time, [R144]	F 225	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 told another resident that a man had touched her inappropriately. [R144] pointed to a male staff down the hall from her when making the statement. The resident shortly after told the staff nurse about [R144's] report. The male staff implicated was leaving the building at that time, as it was the end of the shift; he was directed to not return to the building until contacted. " [R144] is profoundly deaf and requires interpreter for complex conversations. An interview was conducted on 6/7/16, at 9:00 a.m...." Review of the VA log revealed the allegation of sexual abuse had been made on 6/6/16, at 6:00 p.m. however was not reported to the SA until 6/7/16. The clinical record lacked evidence the allegation was reported to the administrator and SA immediately. In addition, the medical record lacked evidence the incident had been documented in the medical record. The significant change Minimum Data Set (MDS) dated 5/19/16, indicated R144 had severely impaired cognition and did not have any psychosis issues which included delusions and hallucinations. The Diagnosis Report dated 6/16/16, indicated R144's diagnoses included dementia and Alzheimer's disease, hearing loss and age related cognitive decline. The communication care plan dated 4/11/16, identified R144 had impaired communication related to hearing loss, and indicated R144 can read lips and used American Sign Language. The care plan directed staff to use visual communication such as facial expressions, white board, writing material, sign language. The cognitive loss/dementia Care Area Assessment (CAA) dated 6/1/16, indicated R144 had both	F 225	the facility states that: F225 It is the policy of Lyngblomsten Care Center that the facility not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility ensures that all violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. The facility provides evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The facility provides that the results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action has been taken. To assure continued compliance the following plan has been implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 short and long term memory loss, had impaired decision making and used American Sign Language (ASL) interpreter and had hearing impairment. On 6/29/16, at 3:01 p.m. the director of nursing (DON) stated he re-called R144 had reported an alleged sexual abuse to another resident and pointed to the staff member. When asked why she was not given an interpreter on 6/6/16, as soon as the facility was made aware of the allegation, DON stated because it was 10:00 p.m. and an American Sign Language (ASL) certified interpreter was not available. DON acknowledged he reported the allegation to the SA and administrator the next morning 6/7/16 even though R144 was able to read lips. When asked why the allegation had not been called to the SA on 6/6/16, at 10:00 p.m. by nursing supervisor DON stated "It was reported by another resident who thought [R144] was delusional. When [R144] pointed down the hallway about 75 feet without her glasses on, not sure she could reliably see that far." DON verified although he completed the investigation on 6/7/16, the additional investigative report for R144 had been submitted late on 6/17/16, three days over the five working days ' time frame. "I thought I just had 2 that were late, I'm sorry, you know I did all the work right away, you can see." The DON verified nursing supervisors know how to make reports, they had held off because they were unsure of the report. When asked if it was the policy of the facility to investigate before reporting allegation of sexual abuse, the DON responded he felt he was supposed to investigate for credibility first.	F 225	Regarding cited residents: With respect to resident R144, the complaint of 6-6-16 was reported to the SA and Administrator/designee on 6-7-16. The investigation was reviewed. Appropriate actions were taken, subsequently, resident R144's care plan has been updated to include delusions and hallucinations and her Social History/Psychosocial/Vulnerability Risk Assessment LTC was updated. R144 has been seen by the Psychiatric Nurse Practitioner and her ability to accurately report assessed. The internal investigation was reviewed for proper notification steps. Actions taken to identify other potential residents having similar occurrences: A facility-wide review of all alleged violations made in the last survey cycle was completed for proper investigations and reporting processes. Measures put in place to ensure deficient practice does not occur: Procedural changes have been made to the reporting processes to clarify reporting timeliness and final investigative report timelines. Reporting and calendar logs have been implemented with review procedures to assure all allegations are properly reported, investigated and finalized. Recording processes have been implemented to assure proper documentation of incidents in the resident's record. Staff have been re-educated on reporting procedures and appropriate staff have been educated on the new investigation and internal/external reporting processes. A reporting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 On 6/29/16, at 4:36 p.m. DON returned to the conference room and stated, " R144 allegation of abuse was called to me at 10:00 p.m. by the nursing supervisor. I told him to give report and leave immediately, I felt that R144 was protected, and I didn't feel I had enough to report [to SA] Before you report, I think we have some obligation- to report- well again we felt we [had to] investigate." DON further stated he needed to set up interpreter services, "I need to figure out what is going on. I know I'm supposed to do an investigation, but feel I have to gather some facts. In hindsight, if it was 2:00 p.m. I would have acted then, though interpreter services are not the easiest thing to get. [R144] is more alert in the morning, you read the subsequent data, I reported it to error on the side of caution, "never suspected reliable- once able to tell us more what and who was said - notes show it was not clear." On 6/29/16, at 3:41 p.m. the associate administrator (AA) was interviewed regarding abuse and reporting to SA for R144. The AA acknowledged the gap in the reporting of the allegation of sexual abuse and verified the expectation was allegations of abuse would be reported immediately to the SA and administrator and a final report, submitted within five days. "My expectation is that we follow the letter of the law." The facility Vulnerable Adult/Abuse Prevention policy revised 3/2015, indicated the following: "1. A Mandated Reporter (MR) who had reason to believe a vulnerable adult (VA) was being or has been maltreated, neglected or abused, including injuries of unknown source, financial exploitation, misappropriation of property and actions that go Against Medical Advice (AMA) shall immediately report that information internally to the	F 225	guidance tool is available to all nursing supervisors and other key staff for quick reference if needed when reporting. Contracting for after-hours interpretive services have been secured and access information is available to those staff responsible for Vulnerable Adult reporting. Effective implementation of actions will be monitored by: Nursing Administration will monitor facility reporting and investigation processes and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will audit all investigations via spreadsheet to assure all necessary steps of investigating and reporting alleged violations have been completed. The data collected will be presented and discussed monthly at the Quality Assurance Committee meetings by the Director of Nursing. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. Completion date for certification purposes only is August 8th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 Administrator, DON, or designee via confirmable methods (directly, verified electronic contact, etc.) The Administrator and DON will be informed of all vulnerable adult investigations immediately. 2. The Administrator, DON, or designee shall immediately report suspected abuse or neglect to the State Agencies, according to all State and Federal Regulations. 3. Initial immediate internal report to the Administrator and DON and immediate external report to State Agencies shall be done according to all State and Federal Regulations, regardless of the resident's diagnosis, or history of repeat care complaints, as those residents may be at higher risk of abuse/neglect... 5. The results of all investigations must be reported to the Administrator and the appropriate state agencies within (5) working days of the discovery of the incident. The investigator will supply the appropriate state agencies information as required..."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow facility policy regarding investigation and immediate reporting to the administrator and State agency (SA) for 1 of 4 residents (R144) who alleged sexual abuse by	F 226	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on	8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 6 staff. Findings include: The facility Vulnerable Adult/Abuse Prevention policy revised 3/2015, indicated the following: "1. A Mandated Reporter (MR) who had reason to believe a vulnerable adult (VA) was being or has been maltreated, neglected or abused, including injuries of unknown source, financial exploitation, misappropriation of property and actions that go Against Medical Advice (AMA) shall immediately report that information internally to the Administrator, DON, or designee via confirmable methods (directly, verified electronic contact, etc.) The Administrator and DON will be informed of all vulnerable adult investigations immediately. 2. The Administrator, DON, or designee shall immediately report suspected abuse or neglect to the State Agencies, according to all State and Federal Regulations. 3. Initial immediate internal report to the Administrator and DON and immediate external report to State Agencies shall be done according to all State and Federal Regulations, regardless of the resident's diagnosis, or history of repeat care complaints, as those residents may be at higher risk of abuse/neglect... 5. The results of all investigations must be reported to the Administrator and the appropriate state agencies within (5) working days of the discovery of the incident. The investigator will supply the appropriate state agencies information as required..." A vulnerable adult (VA) report dated 6/7/16, indicated "On 6/6/16, around supper time, [R144] told another resident that a man had touched her inappropriately. [R144] pointed to a male staff down the hall from her when making this	F 226	conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F226 It is the policy of Lyngblomsten Care Center that the facility develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R144, the complaint of 6-6-16 was reported to the SA and Administrator/designee on 6-7-16. The investigation was reviewed. Appropriate actions were taken, subsequently, resident R144's care plan has been updated to include delusions and hallucinations and her Social History/Psychosocial/Vulnerability Risk Assessment LTC was updated. R144 has been seen by the Psychiatric Nurse Practitioner and her ability to accurately report assessed. The internal investigation was reviewed for proper notification steps. Actions taken to identify other potential residents having similar occurrences: A facility-wide review of all alleged violations made in the last survey cycle was completed for proper investigations and reporting processes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 7 statement. The resident shortly after told the staff nurse about [R144's] report. The male staff implicated was leaving the building at this time, as it was the end of the shift; he was directed to not return to the building until contacted. [R144] is profoundly deaf and requires interpreter for complex conversations. An interview was conducted on 6/7/16, at 9:00 a.m...." Review of the VA log revealed the allegation of sexual abuse had been made on 6/6/16, at 6:00 p.m. however was not reported to the SA and administrator until 6/7/16. The clinical record lacked evidence the allegation was reported to the administrator and SA immediately. In addition, the medical record lacked evidence the incident had been documented in the medical record. The significant change Minimum Data Set (MDS) dated 5/19/16, indicated R144 had severely impaired cognition and did not have any psychosis issues which included delusions and hallucinations. The Diagnosis Report dated 6/16/16, indicated R144's diagnoses included dementia and Alzheimer's disease, hearing loss and age related cognitive decline. The communication care plan dated 4/11/16, identified R144 had impaired communication related to hearing loss, and indicated R144 can read lips and used American Sign Language. The care plan directed staff to use visual communication such as facial expressions, white board, writing material, sign language. The cognitive loss/dementia Care Area Assessment (CAA) dated 6/1/16, indicated R144 had both short and long term memory loss, had impaired decision making and used American Sign Language (ASL) interpreter and had hearing	F 226	Measures put in place to ensure deficient practice does not occur: Procedural changes have been made to the reporting processes to clarify reporting timeliness and final investigative report timelines. Reporting and calendar logs have been implemented with review procedures to assure all allegations are properly reported, investigated and finalized. Recording processes have been implemented to assure proper documentation of incidents in the resident's record. Staff have been re-educated on reporting procedures and appropriate staff have been educated on the new investigation and internal/external reporting processes. A reporting guidance tool is available to all nursing supervisors and other key staff for quick reference if needed when reporting. Contracting for after-hours interpretive services have been secured and access information is available to those staff responsible for Vulnerable Adult reporting. Effective implementation of actions will be monitored by: Nursing Administration will monitor facility reporting and investigation processes and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will audit all investigations via spreadsheet to assure all necessary steps of investigating and reporting alleged violations have been completed. The data collected will be presented and discussed monthly at the Quality Assurance Committee meetings by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 8 impairment. On 6/29/16, at 3:01 p.m. the director of nursing (DON) stated he re-called R144 had reported an alleged sexual abuse to another resident and pointed to the staff member. When asked why she was not given an interpreter on 6/6/16, as soon as the facility was made aware of the allegation, DON stated because it was 10:00 p.m. and an American Sign Language (ASL) certified interpreter was not available. DON acknowledged he reported the allegation to the SA and administrator the next morning 6/7/16 even though R144 was able to read lips. When asked why the allegation had not been called to the SA on 6/6/16, at 10:00 p.m. by nursing supervisor DON stated "It was reported by another resident who thought [R144] was delusional. When [R144] pointed down the hallway about 75 feet without her glasses on, not sure she could reliably see that far." DON verified although he completed the investigation on 6/7/16, the additional investigative report for R144 had been submitted late on 6/17/16, three days over the five business days ' time frame. "I thought I just had 2 that were late, I'm sorry, you know I did all the work right away, you can see." The DON verified nursing supervisors know how to make reports, they had held off because they were unsure of the report. When asked if it was the policy of the facility to investigate before reporting allegation of sexual abuse, the DON responded he felt he was supposed to investigate for credibility first. On 6/29/16, at 4:36 p.m. DON returned to the conference room and stated, " R144 allegation of abuse was called to me at 10:00 p.m. by the	F 226	Director of Nursing. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. Completion date for certification purposes only is August 8th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 9 nursing supervisor. I told him to give report and leave immediately, I felt that R144 was protected, and I didn't feel I had enough to report [to SA] Before you report, I think we have some obligation- to report- well again we felt we [had to] investigate." DON further stated he needed to set up interpreter services, "I need to figure out what is going on. I know I'm supposed to do an investigation, but feel I have to gather some facts. In hindsight, if it was 2:00 p.m. I would have acted then, though interpreter services are not the easiest thing to get. [R144] is more alert in the morning, you read the subsequent data, I reported it to error on the side of caution, "never suspected reliable- once able to tell us more what and who was said - notes show it was not clear." On 6/29/16, at 3:41 p.m. the associate administrator (AA) was interviewed regarding abuse and reporting to SA for R144. The AA acknowledged the gap in the reporting of the allegation of sexual abuse and verified the expectation was allegations of abuse would be reported immediately to the SA and administrator and a final report, submitted within five days. "My expectation is that we follow the letter of the law."	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 10 assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan for 1 of 2 residents (R6) who had been identified with a contracture and was to be on a self-range of motion home exercise program. Findings include: During observation on 6/27/16, at 11:37 a.m. R6 was sitting in a wheelchair. Right arm held close to side of body. Right wrist bent inward 90 degrees index finger pointed straight out and rest of the fingers curled under. Care plan dated 9/3/15, indicated R6 had impaired self-care and mobility related to history of CVA and right hemiparesis (weakness) and required assistance with dressing, grooming, bathing and mobility. Care plan did not address home exercise program. While contracture was identified on MDS and CAA it was not on care plan. Home exercise range of motion was not indicated on care plan or nursing assistant assignment sheets and there were no instructions	F 279	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F279 It is the policy of Lyngblomsten Care Center that the facility use results of assessments to develop, review, and revise the plan of care. That the facility develop comprehensive plans of care for each resident that include measurable objectives and timetables to meet their medical, nursing, mental and psychosocial needs identified in the assessment. That the care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 to staff to monitor or encourage R6 to complete home exercise program. Hand written noted dated 6/28/16, added to the care during survey, instructed staff to "perform gentle AROM [active range of motion] to RUE [right upper extremity' as tolerated." R6's significant change Minimum Data Set (MDS) dated 5/4/16, indicated R6 had diagnoses which included history of a cerebral vascular accident (CVA or stroke), Monoplegia (paralysis of one limb) of the upper limb following a CVA affecting the right dominate side, and cerebral palsy (a disorder that affects muscle tone, movement and motor skills). R6's MDS indicated R6 was moderately cognitively impaired and required assistance with dressing, toileting personal hygiene, bathing and transferring. R6 used a wheel chair for mobility and required assistance for long distances. R6's MDS indicated R6 had functional limitation to upper extremity on one side. Activities of daily living (ADL) function Care Area Assessment (CAA) dated 5/17/16, indicated R6 needed assistance with ADL's and mobility because of CVA and right sided paralysis. CAA indicated R6 had contractures and that the overall goal of care planning was to minimize risks and avoid complications. Review of medical recorded indicated R6 had been discharged from occupational therapy on 8/28/15. Occupational Therapy (OT) Discharge Summary dated 8/28/15, indicated R6 had been seen be OT five times a week for two weeks. R6 had demonstrated limited gains in therapy and continued to require maximum assistance with dressing toileting and feeding. OT had instructed	F 279	describes those services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R6, his care plan has been updated to reflect the home exercise program and new ROM program. R6's contractures and their effect on his ROM has been added to the care plan and identified on the MDS. Staff encouragement of R6's home exercise and ROM program has been added to the Nursing Assistant Assignment Sheets. Resident R6 is currently enrolled in hospice and declines in function are anticipated. Actions taken to identify other potential residents having similar occurrences: All residents with contractures have been reviewed for proper identification on the MDS and care plan interventions. All residents with contractures are identified on the Nursing Assistant Care Sheets with relevant interventions noted. Measures put in place to ensure deficient practice does not occur: Regular periodic interdisciplinary meetings on each neighborhood will include discussions on noted reductions in function, mobility or ROM. Those identified as having reduced ROM will be referred to therapy or physician for appropriate interventions. If the development or worsening of a contracture is unavoidable, a physician's statement detailing the reasoning is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 12 R6 in a range of motion home exercise program and recommended 24 hour care. During interview on 6/27/16, at 11:17 a.m. registered nurse (RN)-A said R6 had contracture of right wrist and index fingers. RN-A said R6 did not have a splint or range of motion program. RN-A verified there was no range of motion program on the care plan or nursing assistant assignment sheet. RN-A said, "He should have a program." During interview on 6/29/16, at 8:02 a.m. occupational therapist (OT)-A reviewed R6's therapy file and said he was discharged from occupational therapy on a home exercise program. OT-A said, "maybe we should have written an order to have nursing encourage him to do it daily." His mini mental state exam [a test for cognitive ability] on 8/21/15, was 23 out of 30. A score of 23 indicates cognitive impairment." During interview on 6/29/16, at 1:15 p.m. the director of nursing (DON) said, "If therapy puts someone on a self-exercise program I would expect them to tell us." DON expected that any resident who had a contracture, would have it care planned and include that the resident should be monitored for decline in function or range of motion. Care Planning procedure revised 3/2015, indicated purpose was that, "Each resident has a care plan that is current, individualized, and consistent with the medical regimen."	F 279	documented in the record. All residents with contractures will be periodically assessed by a licensed therapist for a thorough assessment of the contracture status. Facility policy “Range of Motion-Identification of Declines and Interventions Guidance” has been updated to reflect the periodic assessments and that therapy recommendations are communicated to nursing for identification in the resident care plan with appropriate interventions also added to the Nursing Assistant Assignment Sheets. Staff have been re-educated on identifying, reporting, and treatment of reductions in joint mobility. Contracted therapy staff have been re-educated on notification and communication processes related to range of motion and exercise programming. Effective implementation of actions will be monitored by: Clinical Managers will monitor facility procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete one care plan audit each week for one month and then one care plan audit every other week for two months to assure proper identification and interventions for residents with contractures. Designated staff will observe one Interdisciplinary Team Meeting per week for two months to assure review of reductions in function, mobility and ROM are occurring per plan. The data collected will be presented to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 13	F 279	Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. Completion date for certification purposes only is August 8th, 2016.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 1 residents (R127) who required oxygen. Findings include: On 6/26/16, at 4:21 p.m. an initial interview was started with R127. At 4:40 p.m., during interview, R127's speech was noted to become more abrupt, and more disjointed. R127 had a nasal cannula in nose with tubing behind R127's ear. R127 was sitting in wheel chair. R127's skin was pale, lips were faintly blue. Respiratory rate was 24. A large oxygen tank was at the foot of R127's bed with oxygen tubing attached to transparent humidifier bottle. Surveyor able to see bubbles in humidifier bottle. Portable oxygen tank was sitting on the floor to the left of resident with no tubing	F 282	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F282 It is the policy of Lyngblomsten Care Center that the services provided or arranged by the facility must be provided by qualified persons in accordance with	8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 14 attached to it. The surveyor saw nasal cannula and tubing from large oxygen tank lying on the bed. The surveyor checked the R127's nasal cannula and saw it was not attached to an oxygen source. R127 stated when asked, yes she felt short of breath. The surveyor pressed the call light. After three minutes when no one came to answer call light the surveyor stepped into hall and flagged down a nursing assistant. At 4:45 p.m. nursing assistant (NA)-B entered room and verified R127 oxygen cannula was not connected to oxygen and the large tank was hooked up to a cannula that was lying across the bed. NA-B attached the nasal cannula to R127's portable oxygen tank and turned the oxygen on. NA-B did not check if there was oxygen in tank. Trained medication aide (TMA)-B entered the room and said, "I hooked her up to her oxygen when I started my shift." NA-B took R127 to the dining room table. At 5:04 p.m. NA-B showed surveyor the O2 gauge on R127 ' s portable tank. The liter flow was set at 2.5 liters. Upon request NA-B showed surveyor how to check on oxygen tank to ensure that there was oxygen in it. NA-B held portable tank level by both straps and said the gauge was in the green. TMA-B verified that was how to check a portable tank and that there was oxygen in the tank but it was low. At 5:08 p.m. at surveyors request licensed practical nurse (LPN)-B verified R127's O2 tank was set at 2.5 L and the tank was empty. LPN-B checked portable oxygen tank by holding by one strap at an angle. LPN-B stated portable oxygen tank was to be check by reading the gauge while holding portable tank by one strap. Holding it by two straps would give you an inaccurate reading. LPN-B sent NA-B to refill R127's portable oxygen tank. At 5:15 p.m. NA-B returned with R167's portable oxygen tank and attached nasal cannula	F 282	each resident's written plan of care. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R127 her care plan was reviewed and found to be accurate and appropriate. Review of record shows resident has history of removing and applying oxygen tubing, including changing the tubing from her stationary tank and her portable tank. Care plan interventions have been added and noted on the Nursing Assistant Assignment Sheets, for periodic observations to assure oxygen is properly applied. Actions taken to identify other potential residents having similar occurrences: All residents using oxygen were reviewed to assure appropriate and accurate orders, administration instructions, and care plan interventions are in place. Nursing Assistant Assignment Sheets have been reviewed and updated to accurately reflect any oxygen interventions. Measures put in place to ensure deficient practice does not occur: Nursing staff have been re-educated on the proper use and administration of oxygen, including checking the contents of the liquid oxygen portable tanks. Facility policy has been updated to direct staff to resources of how to check the contents of a tank and/or the flow of oxygen. Clinical Managers have been re-educated on process of Physician Order review. Effective implementation of actions will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 15 to it and turned oxygen on to 2.5 liters. At 5:16 p.m. registered nurse (RN)-B verified R127's oxygen saturations were 91% one minute after oxygen tank was connected to tubing. The care plan dated 12/21/15, indicated R127 had altered respiratory function related to hypoxia (inadequate oxygen supply). Goal was to maintain oxygen saturations at 90% or more. Instructions to staff were administer respiratory medications as ordered, monitor for signs and symptoms of respiratory decompensation through vital signs, lung sounds oxygen saturations, cough change in level of consciousness, behavior shortness of breath. Staff also instructed to provide oxygen and 2-4 liters per minute (LPM) via nasal cannula to keep oxygen saturations at 90%. R127's quarterly Minimum Data Set (MDS) dated 3/16/16, indicated R127 was cognitively intact, used oxygen and diagnoses included hypertension, diabetes, dementia, stroke R127 required assistance of one to two people for dressing grooming toileting and transfers and mobility. R127 Order Summary Report signed by physician and sign and dated 5/24/16, by RN-B did not include order for oxygen usage or flow rate. Order Summary Report did include orders for Oxygen saturations every shift, staff to ensure portable oxygen tank was filled prior to use every shift when utilized, and for staff to change oxygen tubing and set ups weekly on bath sheet. Review of order summary report for April May and June did not include an order for oxygen usage or flow rate.	F 282	monitored by: Nursing Administration will monitor residents who use oxygen and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete two chart audits each week for one month and then one chart audit every other week for two months to assure compliance with facility oxygen policies. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. Completion date for certification purposes only is August 8th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 16	F 282		

The Resident Care Sheet dated 6/23/16, indicated R127 "Has continuous Oxygen at 2 LPM per nasal cannula. Fill portable tank every morning and every afternoon." Resident Care Sheet dated 6/28/16, indicated R127 "Has continuous Oxygen at 2 LPM per nasal cannula. Fill portable tank every morning and every afternoon."

The Telephone order 6/26/16, instructed staff, "Oxygen is continuous a 2.5 LPM per n/c [nasal cannula] due to hypoxemia, due to failed weaning attempt."

Review of Progress Notes for 6/26/16, does not indicate assessment of respiratory status at time of oxygen being off or after oxygen was resumed on 6/26/16.

Review of Treatment Administration Record for the month of June indicated R127's oxygen saturations varied from 91 to 98 with 36 of 72 readings 95% or greater and two of 72 were 91%.

During interview on 6/26/16, at 4:47 p.m. TMA-B said (R127) oxygen is ordered at 2 liters (L) per minutes, sometimes 2.5L when she is short of breath. I hooked her up to her large oxygen tank when I started my shift. (R127) cannot change the cannulas without help but could remove it by herself.

During interview on 6/26/16, at 5:16 p.m. RN-B verified that (R127's) oxygen saturations were 91%, one minute after portable oxygen tank was connected to tubing. RN-B said, "They (staff) should have checked if the tank was full before putting her on it." RN-B verified there was no order for oxygen flow rate or usage on the June

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 17 orders, last set of orders with oxygen on them were signed 2/29/16. RN-B said "I do not know why she is on it (oxygen) I do not think the doctor discontinued it." During interview on 6/26/16, at 6:25 p.m. RN-B said R127 had a two day trial without oxygen in March which she failed. RN-B said the order with rate was not restarted at that time although (R127) has been on the 2.5 liters since then. RN-B said R127's average oxygen saturations on 2.5 LPM were 94 to 95%. RN-B verified the nursing assistants are supposed to put (R127) on oxygen and turn it on to the correct rate. RN-B stated based on the care sheet the nursing assistants should have put the oxygen on at 2 LPM because that was what the care sheets state. RN-B indicated physician orders, Treatment Records and Resident care sheets have been updated with new order for continuous oxygen at 2.5LPM. During interview on 6/29/16 at 1:15 p.m. the director of nurses (DON) said nursing assistants are allowed to apply oxygen and turn the on the oxygen to the correct flow rate but the nurse or TMA has to check that it is correct. DON said, "Staff are supposed to check oxygen tanks before putting them on a resident. We have obtained a laminated poster on how to check if an oxygen tank is full and put it up in the trans-fill room. We were surprised that some of the staff did not know how to check an oxygen tank. We are educating all nursing staff as they come to work. "	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 18 resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 2 residents (R6) who was recommended to have a self-range of motion home exercise program followed through on the recommendations. Findings include: During observation on 6/27/16, at 11:37 a.m. R6 was sitting in a wheelchair. Right arm held close to side of body. Right wrist bent inward 90 degrees index finger pointed straight out and rest of the fingers curled under. During observation on 6/28/16, at 1:23 p.m. R6 was slowly propelling wheelchair with feet toward room. R6 stated that he was excited about starting a new exercise program that the nurse had set up for him. R6 acknowledged he had been given a program to do by therapy last year but he had not done it. R6 stated he felt that his hand was about the same or a little bit better than when he was admitted. R6 said, "I can lift it [right arm] with my left arm." R6's wrist flexed inward. R6 demonstrated able to move fingers with left hand. The care plan dated 9/3/15, indicated R6 had impaired self-care and mobility related to history	F 318	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F318 It is the policy of Lyngblomsten Care Center that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R6, his care plan has been updated to reflect the home exercise program and new ROM program. R6's contractures and their effect on his ROM has been added to the care plan and identified on the MDS. Staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 19 of CVA and right hemiparesis (weakness) and required assistance with dressing, grooming, bathing and mobility. Care plan did not address home exercise program. Hand written noted dated 6/28/16, added during survey, instructed staff to "perform gentle AROM [active range of motion] to RUE [right upper extremity' as tolerated." R6's significant change Minimum Data Set (MDS) dated 5/4/16, indicated R6 had diagnoses that included history of a cerebral vascular accident (CVA or stroke), Monoplegia (paralysis of one limb) of the upper limb following a CVA affecting the right dominate side, and cerebral palsy (a disorder that affects muscle tone, movement and motor skills). R6's MDS indicated R6 was moderately cognitively impaired and required assistance with dressing, toileting personal hygiene, bathing and transferring. R6 used a wheel chair for mobility and required assistance for long distances. R6's MDS indicated R6 had functional limitation to upper extremity on one side. Activities of daily living (ADL) function Care Area Assessment (CAA) dated 5/17/16, indicated R6 needed assistance with ADL's and mobility because of CVA and right sided paralysis. CAA indicated R6 had contractures and that the overall goal of care planning was to minimize risks and avoid complications. Review of medical recorded indicated R6 had been discharged from occupational therapy on 8/28/15. Occupational Therapy (OT) Discharge Summary dated 8/28/15, indicated R6 had been seen be OT five times a week for two weeks. R6 had demonstrated limited gains in therapy and	F 318	encouragement of R6's home exercise and ROM program has been added to the Nursing Assistant Assignment Sheets. Resident R6 is currently enrolled in hospice and declines in function are anticipated. Actions taken to identify other potential residents having similar occurrences: All residents with contractures have been reviewed for proper identification on the MDS and care plan interventions. All residents with contractures are identified on the Nursing Assistant Care Sheets with relevant interventions noted. Measures put in place to ensure deficient practice does not occur: Regular periodic interdisciplinary meetings on each neighborhood will include discussions on noted reductions in function, mobility or ROM. Those identified as having reduced ROM will be referred to therapy or physician for appropriate interventions. If the development or worsening of a contracture is unavoidable, a physician's statement detailing the reasoning is documented in the record. All residents with contractures will be periodically assessed by a licensed therapist for a thorough assessment of the contracture status. Facility policy "Range of Motion-Identification of Declines and Interventions Guidance" has been updated to reflect the periodic assessments and that therapy recommendations are communicated to nursing for identification in the resident care plan with appropriate interventions also added to the Nursing Assistant	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 20 continued to require maximum assistance with dressing toileting and feeding. OT had instructed R6 in a range of motion home exercise program and recommended 24 hour care. On 6/28/16, a telephone order was documented to perform gentle active range of motion to right upper extremity every day. If patient refuses or is painful discontinue. During interview on 6/27/16, at 11:17 a.m. registered nurse (RN)-A said R6 has contracture of right wrist and index fingers. RN-A said R6 does not have a splint or range of motion program. RN-A verified that there was no range of motion program on the care plan or nursing assistant assignment sheet. RN-A said, "He should have a program." During interview on 6/29/16, at 8:02 a.m. occupational therapist (OT)-A reviewed R6's therapy file and said he was discharged from occupational therapy on a home exercise program. During therapy we would work with a resident on the home program for a couple of session to ensure the resident knows what to do and follow the diagrams. OT-A said, "[R6] must have been able to do it without nursing." OT-A said unless nursing is noticing a problem there is no follow up by therapy. Nursing can send down a screen request if there is a problem. OT-A said, "maybe we should have written an order to have nursing encourage him to do it daily." His mini mental state exam [a test for cognitive ability] on 8/21/15, was 23 out of 30. A score of 23 indicates cognitive impairment." OT-A said resident had 30 degrees scaption (shoulder movement) at time of discharge from therapy. During follow up interview on 6/29/16, at 9:18 a.m. OT-A said R6's	F 318	Assignment Sheets. Staff have been re-educated on identifying, reporting, and treatment of reductions in joint mobility. Contracted therapy staff have been re-educated on notification and communication processes related to range of motion and exercise programming. Effective implementation of actions will be monitored by: Clinical Managers will monitor facility procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete one care plan audit each week for one month and then one care plan audit every other week for two months to assure proper identification and interventions for residents with contractures. Designated staff will observe one Interdisciplinary Team Meeting per week for two months to assure review of reductions in function, mobility and ROM are occurring per plan. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. Completion date for certification purposes only is August 8th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 21 range of motion remained essentially the same and that nursing had initiated a range of motion program yesterday. During interview on 6/29/16, at 1:15 p.m. the director of nursing (DON) said, "If therapy puts someone on a self-exercise program I would expect them to tell us." DON stated expected that any resident who had a contracture, would have it care planned and include that the resident should be monitored for decline in function or range of motion. Practice Guideline and Procedures Range of Motion-identification of Declines and Intervention Guidance revised June, 2010, instructed staff "A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion."	F 318		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	F 328		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 22 Based on observation, interview and document review, the facility failed to ensure continuous oxygen was provided for 1 of 1 (R127) who required oxygen. Findings include: On 6/26/16, at 4:21 p.m. an initial interview was started with R127. At 4:40 p.m., during interview, R127's speech was noted to become more abrupt, and more disjointed. R127 had a nasal cannula in nose with tubing behind R127's ear. R127 was sitting in wheel chair. R127's skin was pale, lips were faintly blue. Respiratory rate was 24. A large oxygen tank was at the foot of R127's bed with oxygen tubing attached to transparent humidifier bottle. Surveyor able to see bubbles in humidifier bottle. Portable oxygen tank was sitting on the floor to the left of resident with no tubing attached to it. The surveyor saw nasal cannula and tubing from large oxygen tank lying on the bed. The surveyor checked the R127's nasal cannula and saw it was not attached to an oxygen source. R127 stated when asked, yes she felt short of breath. The surveyor pressed the call light. After three minutes when no one came to answer call light the surveyor stepped into hall and flagged down a nursing assistant. At 4:45 p.m. nursing assistant (NA)-B entered room and verified R127 oxygen cannula was not connected to oxygen and the large tank was hooked up to a cannula that was lying across the bed. NA-B attached the nasal cannula to R127's portable oxygen tank and turned the oxygen on. NA-B did not check if there was oxygen in tank. Trained medication aide (TMA)-B entered the room and said, "I hooked her up to her oxygen when I started my shift." NA-B took R127 to the dining room table. At 5:04 p.m. NA-B showed surveyor	F 328	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F328 It is the policy of Lyngblomsten Care Center that the facility ensure that residents receive the proper treatment and care for special services. Regarding cited residents: With respect to resident R127 her care plan was reviewed and found to be accurate and appropriate. Review of record shows resident has history of removing and applying oxygen tubing, including changing the tubing from her stationary tank and her portable tank. Care plan interventions have been added and noted on the Nursing Assistant Assignment Sheets, for periodic observations to assure oxygen is properly applied. Actions taken to identify other potential residents having similar occurrences: All residents using oxygen were reviewed to assure appropriate and accurate orders, administration instructions, and care plan interventions are in place. Nursing Assistant Assignment Sheets have been reviewed and updated to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 23 the O2 gauge on R127 ' s portable tank. The liter flow was set at 2.5 liters. Upon request NA-B showed surveyor how to check on oxygen tank to ensure that there was oxygen in it. NA-B held portable tank level by both straps and said the gauge was in the green. TMA-B verified that was how to check a portable tank and that there was oxygen in the tank but it was low. At 5:08 p.m. at surveyors request licensed practical nurse (LPN)-B verified R127's O2 tank was set at 2.5 L and the tank was empty. LPN-B checked portable oxygen tank by holding by one strap at an angle. LPN-B stated portable oxygen tank was to be check by reading the gauge while holding portable tank by one strap. Holding it by two straps would give you an inaccurate reading. LPN-B sent NA-B to refill R127's portable oxygen tank. At 5:15 p.m. NA-B returned with R167's portable oxygen tank and attached nasal cannula to it and turned oxygen on to 2.5 liters. At 5:16 p.m. registered nurse (RN)-B verified R127's oxygen saturations were 91% one minute after oxygen tank was connected to tubing. The care plan dated 12/21/15, indicated R127 had altered respiratory function related to hypoxia (inadequate oxygen supply). Goal was to maintain oxygen saturations at 90% or more. Instructions to staff were administer respiratory medications as ordered, monitor for signs and symptoms of respiratory decompensation through vital signs, lung sounds oxygen saturations, cough change in level of consciousness, behavior shortness of breath. Staff also instructed to provide oxygen and 2-4 liters per minute (LPM) via nasal cannula to keep oxygen saturations at 90%. R127's quarterly Minimum Data Set (MDS) dated	F 328	accurately reflect any oxygen interventions. Measures put in place to ensure deficient practice does not occur: Nursing staff have been re-educated on the proper use and administration of oxygen, including checking the contents of the liquid oxygen portable tanks. Facility policy has been updated to direct staff to resources of how to check the contents of a tank and/or the flow of oxygen. Clinical Managers have been re-educated on process of Physician Order review. Effective implementation of actions will be monitored by: Nursing Administration will monitor residents who use oxygen and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete two chart audits each week for one month and then one chart audit every other week for two months to assure compliance with facility oxygen policies. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. Completion date for certification purposes only is August 8th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 24	F 328		

3/16/16, indicated R127 was cognitively intact, used oxygen and diagnoses included hypertension, diabetes, dementia, stroke R127 required assistance of one to two people for dressing grooming toileting and transfers and mobility.

R127 Order Summary Report signed by physician and sign and dated 5/24/16, by RN-B did not include order for oxygen usage or flow rate. Order Summary Report did include orders for Oxygen saturations every shift, staff to ensure portable oxygen tank is filled prior to use every shift when utilized, and for staff to change oxygen tubing and set ups weekly on bath sheet. Review of order summary report for April May and June did not include an order for oxygen usage or flow rate.

The Resident Care Sheet dated 6/23/16, indicated R127 "Has continuous Oxygen at 2 LPM per nasal cannula. Fill portable tank every morning and every afternoon." Resident Care Sheet dated 6/28/16, indicated R127 "Has continuous Oxygen at 2 LPM per nasal cannula. Fill portable tank every morning and every afternoon."

The Telephone order 6/26/16, instructed staff, "Oxygen is continuous a 2.5 LPM per n/c [nasal cannula] due to hypoxemia, due to failed weaning attempt."

Review of Progress Notes for 6/26/16, does not indicate assessment of respiratory status at time of oxygen being off or after oxygen was resumed on 6/26/16.

Review of Treatment Administration Record for the month of June indicated R127's oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 25 saturations varied from 91 to 98 with 36 of 72 readings 95% or greater and two of 72 were 91%. During interview on 6/26/16, at 4:47 p.m. TMA-B said (R127) oxygen is ordered at 2 liters (L) per minutes, sometimes 2.5L when she is short of breath. I hooked her up to her large oxygen tank when I started my shift. (R127) cannot change the cannulas without help but could remove it by herself. During interview on 6/26/16, at 5:16 p.m. RN-B verified that (R127's) oxygen saturations were 91%, one minute after portable oxygen tank was connected to tubing. RN-B said, "They (staff) should have checked if the tank was full before putting her on it." RN-B verified there was no order for oxygen flow rate or usage on the June orders, last set of orders with oxygen on them were signed 2/29/16. RN-B said "I do not know why she is on it (oxygen) I do not think the doctor discontinued it." During interview on 6/26/16, at 6:25 p.m. RN-B said R127 had a two day trial without oxygen in March which she failed. RN-B said the order with rate was not restarted at that time although (R127) has been on the 2.5 liters since then. RN-B said R127's average oxygen saturations on 2.5 LPM were 94 to 95%. RN-B verified the nursing assistants are supposed to put (R127) on oxygen and turn it on to the correct rate. RN-B stated based on the care sheet the nursing assistants should have put the oxygen on at 2 LPM because that was what the care sheets state. RN-B indicated physician orders, Treatment Records and Resident care sheets have been updated with new order for continuous oxygen at 2.5LPM.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 26 During interview on 6/29/16, at 1:15 p.m. the director of nurses (DON) said nursing assistants are allowed to apply oxygen and turn the on the oxygen to the correct flow rate but the nurse or TMA has to check that it is correct. DON said, "Staff are supposed to check oxygen tanks before putting them on a resident. We have obtained a laminated poster on how to check if an oxygen tank is full and put it up in the trans-fill room. We were surprised that some of the staff did not know how to check an oxygen tank. We are educating all nursing staff as they come to work." The Oxygen Administration policy dated 6/9/10, instructed staff that the objective "was to provide save (sic) supplemental oxygen to help maintain hemodynamic stability." In addition it instructed staff to "Obtain and MD [medical doctor]/NP [nurse practioner] order for the administration of oxygen. The order should include the liter flow, route of administration (mask or cannula), parameters for checking oxygen saturation levels. The nurse may determine the type of delivery system to be used if not ordered by the physician/NP." It further instructed staff using portable liquid oxygen tanks that, "The oxygen supply in a portable tank may vary according to the set liter flow. Thus, the tank will checked frequently by the NAR [nursing assistant registered] assigned to the resident to verify the supply." While the policy instructs Nursing assistants to check the tank it does not tell them how to do so.	F 328		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 27 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 441	The preparation of the following plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 28 review, the facility did not ensure staff washed hands when gloves were removed and after pericare for 1of 2 residents observed for cares (R64). In addition, the facility did not ensure linens were stored and transported in a manner to prevent contamination on 2 of 3 units. Findings include: Care observation: During observation of morning cares for R64 on 6/28/16, at 7:08 a.m. nursing assistant (NA)-A put on a pair of gloves, assisted R64 to transfer to wheelchair, and handed R64 glasses. NA-A changed gloves and put new gloves on without washing hands or using sanitizer. NA-A had R64 stand up using the transfer bar and removed the soiled and urine soaked incontinent brief. R64 used the toilet. NA-A changed gloves without washing hands and stripped wet sheets off R64's bed. NA-A then obtained a shirt from R64's drawer and assisted R64 to remove night gown. R64 washed her face then NA-A washed R64's upper body and put on a tee shirt. NA-A had R64 stand and wiped R64's buttocks with a wash cloth. There was brown stool on the wash cloth and gloves. NA-A put the fecal soiled wash cloth on the sink's edge. NA-A put a clean incontinent brief on R64 and pulled R64's pants up. R64 sat in wheelchair. NA-A changed gloves without washing hands and applied R64's back brace and then put on R64's shirt. NA-A removed the trash from bathroom. NA-A removed the fecal soiled wash cloth from the sink's edge. NA-A put a towel on R64's front. NA-A combed R64's hair with gloved right hand while holding toothbrush in gloved left hand. NA-A handed R64 glasses and applied toothpaste to tooth brush and handed it to R64. The sink had not been disinfected prior to	F 441	correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F441 It is the policy of Lyngblomsten Care Center that the facility establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Lyngblomsten requires that staff wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R64, she was monitored to assure no negative outcomes resulted from the infection control breach. Resident currently infection free. Residents on the Norway neighborhood have been monitored and show no increase in infections or other negative effects from the poor infection control practices observed on the 6-28-16. Actions taken to identify other potential residents having similar occurrences: All residents receiving direct care are at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 29 R64 brushing their teeth. Linen cart observation: On 6/28/16, during frequent observation from 5:57 a.m. to 12:27 p.m. on Norway Unit. -At 5:57 a.m. there was a multi shelf linen cart with a dark blue cover up against the wall across room 379. The cover was pulled back over the top of the linen cart, exposing the entire front of the cart and the right side of the cart bottom shelf. The cart contained towels, wash cloths sheets and pillow cases. -At 6:17 a.m. registered nurse (RN)-E walked past open cart. -At 6:23 a.m. RN-D walked past cart without covering the cart. -6:43 a.m. the trained medication aide (TMA)-A removed towels and wash clothes from linen cart and did not cover the linen cart. -6:51 a.m. housekeeper-A put mop bucket with soiled water and soiled mop next to linen cart with mop handle touching the cart. -6:53 a.m. female resident wheeled by cart. -6:59 a.m. RN-D walked by linen cart. -7:01 a.m. RN-D walked by linen cart. -7:07 a.m. NA-A got several wash cloths and towels off the linen cart and did not cover the linen cart. - 8:35 a.m. NA-A walked to the dining room with both arms full of clothing protectors held tight against her body. NA-A put the clothing protectors on the cart next to the wall by the kitchenette. (Earlier that morning NA-A was observed to have provided bowel care with stool present to a residen. In addition, NA-A did not wash their hands after changing gloves during that process.) -8:37 a.m. linen cart cover remained open. The soiled mop bucket was moved away from the linen cart.	F 441	risk for infection if proper infection control practices are not maintained. To assure continued compliance, see system measures below. Measures put in place to ensure deficient practice does not occur: All staff have been re-educated on proper infection control practices with particular focus on hand washing/disinfection process and sequence. All staff have been re-educated on the proper handling of linens, clean and soiled, and the process for disinfecting a surface. Neighborhood specific linen carts have been removed from service. Infection surveillance and tracking continues with analysis of data used to determine if staff practices are contributing to the development and transmission of infections. New data analysis includes infection data cross referenced by area with specific staffing to determine if trending can be attributed to specific staff. Effective implementation of actions will be monitored by: Infection Preventionist will monitor facility adherence to practices, polices and/or procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Infection Preventionist and/or designee will complete 5 audits each week for one month and then 5 audits every other week for two months to include proper compliance with procedures. The data collected will be presented to the Quality Assurance committee by the Infection Preventionist. The data will be reviewed/discussed at the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 30 -9:07 a.m. The TMA-A got several wash cloths and towels off the linen cart, which was still open. -10:03 a.m. linen cart remained open. -12:24 p.m. linen cart remains open. TMA-A verified that the linen cart had been open the entire shift. TMA-A said, "We are supposed to keep it closed to keep the linens clean." During interview on 6/28/16, at 12:27 p.m.NA-A acknowledged holding clothing protectors against uniform. NA-A said most of the time, " I use the cart to get clothing protectors, but I was in a hurry. NA-A said, "I am supposed to carry linens so that they do not touch my uniform." When asked about washing hands after removing gloves and before putting on new gloves, NA-A said replied, "It depends on how busy I am, I usually remove the gloves and then wash my hands before putting on new gloves. I usually change my gloves after I wipe someone's bottom especially if they have had a bowel movement." NA-A said acknowledged not washing hands between glove changes, putting soiled washcloths and towels on the sink, not wiping sink down before having resident brush her teeth. During interview on 6/28/16, at 1:04 p.m. RN-B said the staff are to cover the linen cart after they get linens out of it. RN-B said, "I expect staff to hold linens clothing protectors away from their uniform. We are taught that in school because your uniform is dirty." RN-B said when staff change their gloves, they are to wash their hands. They are to change gloves and wash hands after doing pericare. Staff are not to put dirty linens on the sink. On 6/29/16, at 10:51 a.m. the infection control interview was completed with RN-F and RN-G.	F 441	monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. Completion date for certification purposes only is August 8th, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 31 When asked when infection control training was provided to staff RN-F stated was provided annually and all the staff were to do an in-service on-line. RN-F also stated live in-services were providing on the units depending the situation. When asked when hand-washing training was offered, RN-F stated the staff was trained annually and anytime an issue had been identified staff got reminders. RN-F stated at time when going through the units if she noticed anything she would remind staff to follow the hand washing protocol. When asked what she would expect of staff to do with gloving and how often were staff trained on gloving, RN-F stated hand washing and gloving was included in the yearly on-line training and staff also got training on the spot if she saw a staff walking with gloves around. RN-F stated staff were supposed to change gloves with pericare, wash hands then don another pair to continue with cares. When asked the facility clean linen transportation policy was RN-F stated policy directed staff to "carry the linen away from your body and uniform ..." Glove Technique (Non Sterile) revised 2/2010, instructs staff to: "Remove gloves promptly after use, before touching non contaminated items and environmental surfaces, and before going to another resident, and wash hands immediately to avoid transfer of microorganisms to other residents or environments."	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	C 06/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE SAINT PAUL, MN 55108**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted June 26th through June 29th 2016 and two complaints investigations were also completed at the time of the standard survey. An investigation of complaints H5247079 and H5247078 was completed and were found not to be substantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/29/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE** **SAINT PAUL, MN 55108**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/29/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE** **SAINT PAUL, MN 55108**

(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 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lyngblomsten Care Center is a 4-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1976, an addition was constructed to the South side that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. All resident rooms are equipped with single station smoke detection. The facility has a capacity of 237 beds and had a census of 227 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE** **SAINT PAUL, MN 55108**

(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 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 120 of 237 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0900 and 1330 on 6/28/2016 observations revealed that the following room doors did not positively latch: Rooms 163a, 243, A261, A346, A329 Closet door and curtains in the halls throughout	K 018	K018 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 101 LSC (00) Section 19.3.6.3, the doors to rooms 163a, 243, A261, A346, and A329 will be adjusted so that they positively latch. All bi-fold closet doors will be equipped with latches and curtains on closet doors will be removed. The Physical Plant Director will be responsible to ensure all corrections are made and for monitoring to prevent a reoccurrence of the deficiency. Date completed: 8-8-16	8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE SAINT PAUL, MN 55108**

(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 018	Continued From page 3 the facility do not meet code of corridor doors. The deficient practice was observed by the Director of Environmental Services (JT).	K 018		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 90 of the 237 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0900 and 1330 on 6/28/2016 observations revealed that smoke barriers had penetrations at the following locations: Above ceiling at the 1st floor East Wing smoke doors Above ceiling at the 2nd floor East Wing smoke doors Above the ceiling at the 3rd floor West Wing smoke doors The penetrations will all need to be sealed on	K 025	K025 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 101 Section 19.3.7.3 and 8.3.4.1, the penetration areas above the ceiling at the 1st floor east wing, 2nd floor east wing, and 3rd floor west wing will be sealed on both sides. The Physical Plant Director will be responsible to ensure the corrections are made and for monitoring to prevent a reoccurrence of the deficiency. Date completed by: 8-8-16	8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE SAINT PAUL, MN 55108**

(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 025	Continued From page 4 both sides of the smoke barrier. The deficient practice was observed by the Director of Environmental Services (JT).	K 025		
K 062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 0900 and 1330 on 06/28/2016, it was observed that: 1) The sprinkler head in front or the Transitions Coordinator's Office was not operable due to being painted over the head. This deficiency was verified by Director of Environmental Service (JT) at the time of discovery.	K 062	K062 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 25(99) Section 9.2.7, the sprinkler head in front of the Transition Coordinator's office will be replaced. The Physical Plant Director will be responsible to ensure the correction is made and for monitoring to prevent a reoccurrence of the deficiency. Date completed by: 8-8-16	8/8/16
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator	K 144	K144 To meet the requirement of 42CFR,	8/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE** **SAINT PAUL, MN 55108**

(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 144	Continued From page 5 in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 0900 and 1330 PM on 06/28/2016, based on review of available documentation it was revealed that there was no Letter of Reliability for the natural gas generator. This deficient practice was verified by the Director of Environmental Services (JT).	K 144	Subpart 483.70(a), NFPA 110- 1999 and NFPA 99, Section 3-4.1.1.2, a Letter of Reliability for the natural gas generator will be acquired and stored on-site. The Physical Plant Director will be responsible to ensure the correction is made and for monitoring to prevent a reoccurrence of the deficiency. Date completed by: 8-8-16	