



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 27, 2025

Administrator
Lyngblomsten Care Center
1415 ALMOND AVENUE
SAINT PAUL, MN 55108

RE: CCN: 245347
Cycle Start Date: June 5, 2025

Dear Administrator:

On July 28, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Correction of the Life Safety Code deficiency cited under K521 at the time of the July 28, 2025 abbreviated standard extended survey, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of September 18, 2025, has been approved or forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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Electronically delivered

August 27, 2025

Administrator
Lyngblomsten Care Center
1415 ALMOND AVENUE
SAINT PAUL, MN 55108

Re: Reinspection Results
Event ID: 3FKO-H2

Dear Administrator:

On July 23, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 5, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 30, 2025

Administrator
Lyngblomsten Care Center
1415 Almond Avenue
Saint Paul, MN 55108

RE: CCN: 245347
Cycle Start Date: June 5, 2025

Dear Administrator:

On June 5, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 5, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by December 5, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

Lyngblomsten Care Center

June 30, 2025

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A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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

PRINTED: 07/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245347	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2025
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments	E 000			
	On 6/2/25-6/5/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance.				
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 6/2/25-6/5/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were reviewed with NO deficiencies cited.				
	H53475950C (MN00113419) H53476007C (MN00110334) H53476008C (MN00107630) H53476009C (MN00110666)				
	The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.				
	Upon receipt of an acceptable electronic POC, an				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/09/2025

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

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F 000	Continued From page 1	F 000			
F 554 SS=D	onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained. Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed and a provider order obtained to self-administer medications for 1 of 3 residents (R13) reviewed for medication administration. Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 4/14/25, indicated severely impaired cognition and diagnoses of Alzheimer's disease (a progressive neurological disorder affecting a person's memory, thinking, and behavior), heart failure and anxiety. The MDS indicated R13 required partial to moderate assistance for oral hygiene and substantial to maximum assistance for personal hygiene cares. R13's self-administration of medication assessment dated 11/20/23 indicated R13 did not wish to self-administer her medications. R13's undated order summary report included the following orders:	F 554			7/18/25
			The preparation of the following plan of correction for this deficiency 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 deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F554 It is the policy of Lyngblomsten that each resident has the right to self-administer medications if the interdisciplinary team has determined that the practice is clinically appropriate. To assure continued compliance the following plan has been implemented: Regarding cited residents: Resident 13 had a Self Administration of Medication assessment completed which indicates they wish to self-administer their nebulizer treatments after set-up. The		

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F 554	Continued From page 2 - "Resident is not capable of safely self-administering medications", dated 10/31/23. - "Albuterol Sulfate Inhalation Nebulization Solution (Albuterol Sulfate) 3 milliliters (mL) inhale orally via nebulizer three times a day for cough or difficulty breathing", dated 3/13/25. R13's care plan was reviewed on 6/2/25, and revealed a lack of documentation of an assessment she was okay to self-administer medications. During a continuous observation on 6/2/25 starting at 1:23 p.m., a buzzing noise was heard from outside R13's room. At 1:24 p.m., trained medication aide (TMA)-A walked out of R13's room and back to a medication cart, leaving R13's door open. Inside R13's room, a nebulizer treatment machine was observed to be running and causing the buzzing noise heard. There was tubing going from the nebulizer treatment machine to a mask that covered R13's nose and mouth, and connected below the mask was a medicine cup with liquid condensation inside. R13 sat in her wheelchair inside her room facing the nebulizer treatment machine that was plugged into the wall. TMA-A was observed going from the medication cart into other resident rooms and back to the medication cart during this time. At 1:32 p.m., TMA-A returned R13's room and announced, "time is up." R13 had removed the mask from her face and was holding it in her lap. R13 stated to TMA-A, "I don't want it on. I have had worse colds than this." TMA-A responded, "you took it off," and told R13 would need to update the doctor if she did not want the treatment any longer. TMA-A offered a drink of	F 554	electronic medication administration (EMAR) record staff use to prepare and document medication administration indicates that resident 13 wishes, and is safe, to self-administer their nebulizer treatments after set-up. Actions taken to identify other potential residents having similar occurrences: All other residents who have been assessed to self-administer medications have been reviewed. Additionally, all residents receiving nebulizer treatments have been reviewed to determine, if they have orders to self-administer the treatment, they continue to be safe to do so. If they did not have a self-administer order, they have been approached to determine if they desire to self-administer the treatment. Those that have expressed a desire to self-administer and were not previously assessed have been assessed and, if appropriate, have been care planned to self-administer. Measures put in place to ensure deficient practice does not occur: Facility Self-Administration of Medications policy has been reviewed and no revisions were necessary. Those staff responsible for administering medications have been re-trained on the facility procedure for identifying residents with orders to self-administer medications and what and how to report should a resident state they no longer wish to self-administer or be unsafe to do so. Any reported wish to stop or inability to continue to self-administer medications safely will prompt the completion of the Self Administration of Medication assessment.		

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F 554	Continued From page 3 water and attempted to complete the medication pass, however R13 began to cry, spit out her medications and stated she wanted to leave. During interview on 6/2/25 at 1:37 p.m., TMA-A stated R13 had been "having a cough" and was taking a scheduled nebulizer treatment before breakfast and after lunch for the cough. TMA-A stated R13 did not like the afternoon nebulizer treatment but took the morning treatment "well". TMA-A confirmed she administered the nebulizer treatment and left R13 in her room unsupervised while she finished her treatment. TMA-A stated she normally kept the mask on but today was not normal for her. TMA-A stated R13 should have an order in her medication administration record (MAR) stating it was okay for her to be left alone (or unsupervised) to finish her nebulizer treatment. TMA-A was unsure about the self-administration assessment but indicated the nursing manager would know. TMA-A expected there to be an order in place indicating R13 could complete her nebulizer treatment on her own. TMA-A reviewed MAR and identified for R13; Albuterol Sulfate Inhalation Nebulization order and opened the administration instructions and stated, "it doesn't have all the details in there." TMA-A was unable to locate a provider order indicating R13 was okay to self-administer her nebulizer treatment, however stated the MAR banner or administration instructions was where it should be. During interview on 6/2/25 at 1:47 p.m. with registered nurse (RN)-A, indicated a resident who wished to self-administer medications, including complete their nebulizer treatment after set-up unsupervised, would need a provider's order and an assessment. RN-A reviewed R13's orders and			F 554	Also, any resident with a current order to self-administer medications will be assessed quarterly or with any change in condition. Effective implementation of actions will be monitored by: Facility Nursing Administration will be responsible to oversee the successful and ongoing completion of the actions and measures implemented to identify and prevent any deficient practice. Initially, weekly audits will be completed for all residents with current or new self-administration of medication orders for proper assessment and nursing judgement for one month. Subsequently, audits will be completed biweekly for two months. Those responsible to maintain compliance will be: The Director of Nursing, or designee, will be responsible to assure that proper actions, measures and monitoring have been completed correctly. Those findings will be reported to the Quality Assurance committee which will determine any ongoing audits. Completion date for certification purposes only is 7-18-25		

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F 554	Continued From page 4 identified an order dated 10/31/23, that indicated R13 was not able to self-administer medications. RN-A confirmed this order would include nebulizer treatments. RN-A reviewed R13's electronic health record (EHR), including her MAR, and confirmed staff should stay with R13 for the duration of the nebulizer treatment to ensure she kept the mask on. RN-A explained if a resident wished to self-administer medications, staff were expected to obtain an order and perform an assessment to determine if they could safely do so. During interview on 6/5/25 at 8:45 a.m. with RN-B, indicated if a resident had an order to self-administer their medications, it should be in the MAR and/or in the administration instructions for staff to see. During interview on 6/5/25 at 9:56 a.m., the director of nursing (DON) expected staff to follow the facility's self-administration policy and procedure. Facility Self-Administration of Medications policy revised 5/22, indicated the facility would allow residents to self-administer medications and/or treatments if the resident wished "AND" if the resident was assessed to be capable of safely self-administering medications. The policy directed staff to complete a self-administration of medication assessment and if the resident wished to self-administer and was determined to be safe to do so, to obtain a physician's order to self-administer. Further, the policy guided staff on the specificity of the self-administration order, including any modifications (if any) determined during the assessment.	F 554			

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F 577 F 577 SS=C	Continued From page 5 Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure complaint investigation survey results were readily accessible and available for review within the campus. This had potential to affect all 207 residents, visitors, and their families who could wish to review the information. Findings Include:	F 577 F 577			7/18/25
			The preparation of the following plan of correction for this deficiency 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 deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions		

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F 577	Continued From page 6 During the recertification survey on 6/2/25 at 12:21 p.m., a binder labeled survey results hung on the wall to the left of the information board located in a hallway on the 1st floor, adjacent to the front desk and contained the following results: Recertification survey dated 3/14/24 Abbreviated complaint survey results dated 5/21/24. The facility binder lacked documentation in the form of a CMS 2567 (Formal investigation documentation required by the Centers for Medicare and Medicaid Services-CMS) for investigations or standard surveys completed during the following dates: 6/27/24, abbreviated complaint survey results, 7/29/24, abbreviated complaint survey results, 8/29/24, abbreviated complaint survey results with F578- cited at J. 1/17/25, standard abbreviated survey results.. During interview on 6/2/25 at 6:17 p.m., the administrator stated the director of nursing was responsible for maintaining the binder. The director of nursing (DON) entered the office and stated the past survey results will be printed and placed in the binder. During an interview on 6/4/25 at 11:00 a.m., R63 stated survey results are not available for residents to review. Policies related to survey results were requested, but no policies were received.			F 577	of State and Federal law. Without waiving the foregoing statement, the facility states that: F577 It is the policy of Lyngblomsten that each resident has the right to examine the results of the most recent survey conducted by surveyors and any plan of correction. Also, the facility will post in a readily accessible location these results of the most recent survey and make available any reports of any surveys, certifications or complaint investigations during the preceding 3 years upon request. To assure continued compliance the following plan has been implemented: Regarding cited residents: No specific residents were identified, but all residents had the potential to be affected by this deficiency. Measures put in place to ensure deficient practice does not occur: Within hours of the surveyor inquiring about who was responsible for assuring all survey, certification and complaint investigation reports were properly posted. The facility has made available in facility lobby area a binder with a printed copy of the most recent survey including the facility plan of correction and any subsequent extended surveys, and any deficiencies resulting from and subsequent complaint investigations. Additionally, the facility has posted signage with the binder indicating the preceding 3 years of surveys, certifications, and complaint investigations were available upon request from the		

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F 577	Continued From page 7	F 577	receptionist or House Supervisor. Effective implementation of actions will be monitored by: Administration will monitor the binder which houses the readily available required reports to assure the required reports are present and observe that the signage indicating the preceding 3 years of required reports are available upon request. The administrator will also verify the reports are available. The administrator will complete these tasks weekly, any missing reports will be noted, obtained, and placed in the appropriate locations to maintain compliance. Those responsible to maintain compliance will be: The administrator will report directly to the Quality Assurance committee, as needed, their findings and any actions taken to maintain compliance. Completion date for certification purposes only is 7-18-25		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,	F 604			7/18/25

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F 604	Continued From page 8 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure freedom of movement was not restricted for 1 of 1 resident (R143) who was reviewed for physical restraints. Findings include: R143's quarterly Minimum Data Set (MDS) assessment, dated 4/16/25, identified severely impaired cognition. R143's diagnoses included; Parkinson's disease (a chronic progressive neurological disorder), dementia, and progressive neurological conditions accompanied by a psychotic disorder. R143 required maximum assistance to ambulate ten feet and was fully dependent on others when using the wheelchair. They also needed maximal assistance for transfers, including rolling from side to side, seating, and positioning in bed. A bed alarm was used daily.	F 604	The preparation of the following plan of correction for this deficiency 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 deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F604 It is the policy of Lyngblomsten that each resident be free from any physical or chemical restraints not required to treat the resident's medical condition. To assure continued compliance the following plan has been implemented:		

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F 604	Continued From page 9 R143's care plan reviewed on 4/10/25, identified interventions for self care deficits, fall risk, and mood enhancement. The interventions included placing the resident in the common area recliner to engage in activities-such as watching the news-and for staff to observe and intervene when R143 attempted to self transfer. Staff were encouraged to keep R143 in public areas whenever not eating or napping. Furthermore, the care plan recognized impaired mobility secondary to impaired balance and unsteady gait. R143 required assistance from two staff members with a walker; one to two staff for bed mobility, repositioning, sitting up, and rolling side to side; and that a mechanical lift was used when R143 became stiff. R143 was able to propel self short distances but needed assistance for longer distances or when off the unit. R143's active providers orders last reviewed 5/6/25, identified a pressure alarm and pads but lacked an order for restraints. R143's quarterly Interdisciplinary Care Conference report dated 4/28/25, identified family member (FM)-A attended the conference and requested the television on when R143 was in the lounge area and recommended which channels were preferred and suggested R143 held a book for comfort. R143's progress notes dated 5/10/25 at 1:55 p.m., indicated R143 had more than one fall in the past three months, had balance and decreased muscular coordination and used medications that placed R143 at moderate risk for falls.	F 604	Regarding cited residents: Resident 143 has been reassessed by Nursing using the facility Physical Device Evaluation assessment and Therapy to benefit from use of a recliner. Resident and family state the resident prefers to use the recliner during the day when relaxing and reading or watching television, this was his pattern prior to admission and his continued preference. Recliner remote has been upgraded allowing resident to operate recliner more easily and call light added in lounge area for resident to alert staff to his needs when in recliner as able. Actions taken to identify other potential residents having similar occurrences: All residents who use a recliner have been assessed using the facility Physical Device Evaluation assessment to determine the level of benefit or restriction each might create. Plans of care have been revised as necessary so recliner is not deemed a restraint, either by discontinuing the use of the recliner or modifying its use. Measures put in place to ensure deficient practice does not occur: Facility reviewed Physical Device Evaluation and Restraint Use policies and a slight revision was made to the Physical Device Evaluation to more clearly indicate a recliner as a device. Clinical staff responsible for completing Physical Device Evaluation assessments have been re-trained on when and how to complete the assessment. Facility has collaborated with lead Occupational Therapist on the use of recliners and what		

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F 604	Continued From page 10 R143's progress notes dated 5/16/25 at 6:33 p.m., indicated R143 was screened by occupational therapy (OT) post fall, was not a candidate for OT due to the lack of following directions and declined in basic activities of daily living (BADL) and needed extensive assist since admission despite therapy intervention. R143's progress notes dated 5/31/25 at 6:12 p.m., indicated R143 self-transferred and was seen walking around his room unassisted and indicated R143 was not stable walking on his own and brought out to the nurse's station for one-on-one cares. R143's electronic medical record (EMR) lacked documentation for a medical diagnosis treated by use of the electric recliner. Furthermore, the medical record failed to show an assessment or R143's ability to rise independently out of the chair/recliner. During an interview on 6/2/25 at 12:30 p.m., FM-A stated staff placed R143 in the common area in the chair, reclined, with his feet up because the bed alarm can no longer be used. The recliner was the only place staff could keep him because of the recent falls. During an observation on 6/3/25 at 3:52 p.m., R143 was in the common area, in a recliner with both feet up. The recliner remote was hung over the back of the chair. R143's personal paid companion was seated to the right and two other residents were in their wheelchairs. No staff were present. During an interview on 6/4/25 at 8:54 a.m., registered nurse (RN)-C stated R143 can't	F 604	would constitute them being deemed a restraint and what they need to assess when evaluating a resident for use of a recliner and how to communicate their determination to nursing. Effective implementation of actions will be monitored by: Nursing Administration will conduct weekly audits of Physical Device Evaluation assessments completed for accuracy for 2 months, then biweekly for 2 months. Audits finding will be reported to the Quality Assurance Committee. Those responsible to maintain compliance will be: The Director of Nursing, or designee will monitor the successful completion of audits and review the findings and make any adjustments to the facility process for evaluating the use of recliners as potential restraints. Quality Assurance committee will determine any ongoing audits. Completion date for certification purposes only is 7-18-25		

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F 604	Continued From page 11 activate the chair, and the wife requested the use of the recliner. RN-C further stated any assessment would be done by OT and was not aware of any completed assessment. During an observation on 6/4/25 at 9:54 a.m., R143 was in the recliner in the common area, both feet were up. R143 was awake and looking around the room. The remote was placed arms reach away on the heat register. During an interview 6/4/25 at 11:42 a.m., FM-A stated no consent, or waiver was signed that approved the use of the recliner. During an interview on 6/4/25 at 11:46 a.m., director of therapy (DOT) stated R143 had been assessed for transfers, but never assessed for a recliner. During an interview on 6/4/25 at 11:46 a.m., the director of therapy (DOT) stated R143 was assessed for transfers only and never assessed for safety with the use of an electric recliner. The DOT was not aware of any assessments ever completed for a lift chair or recliner. During an Interview on 6/5/25 at 7:09 a.m., the director of nursing (DON) stated he confirmed with the nurse manager on the unit that R143 cannot get up from the recliner, but felt the recliner was a safe intervention and now staff could observe and intervene as he is in the lobby and not in his room. During an interview on 6/5/25 at 8:29 a.m., occupational therapy (OT)-A confirmed no referral was received to assess the safety and use of the electric recliner for R143 furthermore, an			F 604			

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F 604	Continued From page 12 assessment would be requested for a recliner only if a pressure injury occurred that required a cushion or if a resident had fallen out of a recliner. OT-A was aware of assessments for recliners and completed those at other facilities, then confirmed R143 had not been assessed to use the recliner. Restraint Use policy revised 5/21, identified the use of physical restraint was prohibited for discipline or convenience, unnecessarily inhibit a resident's freedom of movement or activity. Convenience was defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest. "Freedom of movement" means any change in place or position for the body or any part of the body that the person is physically able to control. "Physical Restraint" is defined as any manual method, physical or mechanical device, equipment, or material that meets all the following criteria: is attached or adjacent to the resident's body, cannot be removed easily by the resident, restricts the resident's freedom of movement or normal access to his/her body. Physical Device Evaluations policy revised 6/22, identified evaluations for any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The guidelines identified an atypical method, or device is considered any intervention or equipment that is nonroutine or would not be considered standard or required in the normal delivery of care. Some examples of			F 604			

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F 604	Continued From page 13	F 604			
F 641 SS=D	atypical methods or devices are Geri-chairs, wedge cushion in wheelchairs, bed placed against a wall for purposes other than room décor/style, anti-roll back wheelchairs. Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 641			7/18/25
			The preparation of the following plan of		

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F 641	Continued From page 14 facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 resident (R200) reviewed for hospitalization. Findings include: R200's discharge Minimum Data Set (MDS) dated 3/6/25, indicated R200 admitted to facility on 2/10/25, from a Short-Term General Hospital, and discharged from facility on 3/6/25, discharging to Short-Term General Hospital. R200's progress note dated 3/5/25 at 10:00 a.m., indicted R200 discharge home back to [name of assisted living] signed onto hospice so no home services. R200's nursing progress note dated 3/6/25 at 11:04 a.m., indicated R200 discharged to [name of assisted living]. On 6/4/25 at 10:05 a.m., registered nurse (RN)-F, know as a MDS coordinator reviewed R200's MDS dated 3/6/25, and confirmed the MDS was inaccurately coded and R200 discharged home and not to the hospital. RN-F stated the MDS was expected coded correctly and correction would need to be completed. On 6/4/25 at 2:49 p.m., the director of nursing (DON) stated the MDS was expected to be accurate and the MDS coordinators follow the MDS RAI (Resident Assessment Instrument) manual. Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual dated 10/24, indicated			F 641	correction for this deficiency 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 deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F641 It is the policy of Lyngblomsten that each assessment completed is accurate and that each individual who completes a portion of the assessment signs and certifies the accuracy of that portion of the assessment. To assure continued compliance the following plan has been implemented: Regarding cited residents: Resident 200s MDS discharge location was corrected within moments of the surveyors questioning of the MDS Coordinator responsible for the error. Actions taken to identify other potential residents having similar occurrences: All staff responsible for completing any portion of the MDS have been retrained on the importance of accuracy. Measures put in place to ensure deficient practice does not occur: MDS Case Manager has initiated random audits of MDS prior to submission for accuracy. Facility employs third party software to review MDS for logic errors which alerts staff to possible accuracy issues. Accuracy related to discharge		

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F 641	Continued From page 15 In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident ' s medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident ' s actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment.	F 641	locations or other data points, not verifiable by the third-party software will be double checked by an MDS Coordinator not responsible for the overall completion of the MDS. Effective implementation of actions will be monitored by: Nursing Administration will be responsible to ensure that all MDS submitted are accurate, overseeing the audits completed by the MDS Case Manager. Nursing Administration will verify that at least 80% of all MDS completed will be audited for those areas not verifiable by the third-party software for the first month, then 60% for the following 2 months. Those responsible to maintain compliance will be: The Director of Nursing, or designee will monitor the auditing schedule and findings and adjust the MDS completion process and/or the auditing schedule as needed. The Quality Assurance committee will determine the need for any ongoing audits. Completion date for certification purposes only is 7-18-25		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This	F 676			7/18/25

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F 676	Continued From page 16 includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently utilize a communication device or provide an interpreter for 1 of 1 resident (176) reviewed who was deaf and used ASL to communicate care needs. Findings Include: R176's significant change Minimum Data Set	F 676			
			The preparation of the following plan of correction for this deficiency 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 deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions		

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F 676	Continued From page 17 (MDS) assessment dated 4/17/25, identified no cognitive impairment, primary language was American sign language (ASL), and an interpreter was needed to communicate with doctors and health care staff. R176's care plan revised on 12/3/24, identified impaired communication. R176's care plan identified methods for communicating such as short, direct simple phrases, visual aids, and indicated please provide me with an ASL interpreter for all significant meetings/interactions such as care conferences, cognitive/mood assessments, etc. R176's active provider orders last reviewed 5/5/25, indicated weekly pain and skin assessments, daily ambulation program and a fluid restriction order which could have required staff to communicate with R176. During an initial interview on 6/2/25 at 1:11 p.m., R176 wrote on a notebook, some of the staff do not know how to use the iPad to contact the ASL interpreter and wrote on a notebook to communicate. R176 wrote my preference was the ASL interpreter be used with all cares because writing in ASL structure confuses staff that are non-English speaking. An ASL Interpreter was used for the remainder of the interview and through the interpreter R176 expressed concerns that aids and nurses do not understand me and it has always been my preference to use the ASL interpreter. During an interview on 6/3/25 at 4:00 p.m., R176 typed on a word document that staff did not use the iPad interpreter with any interactions or cares today and that only the social worker used the			F 676	of State and Federal law. Without waiving the foregoing statement, the facility states that: F676 It is the policy of Lyngblomsten that each resident is comprehensively assessed to make certain they receive the care and services needed to ensure the residents abilities to complete their activities of daily living do not diminish unless such decline is unavoidable. To assure continued compliance the following plan has been implemented: Regarding cited residents: Resident 176s care plan has been updated to reflect their preference to use the virtual American Sign Language (ASL) interpreting service via the iPad tablet- this preference had not been previously communicated to the facility staff. Those staff responsible for resident 176s care have been trained/re-trained on the location and operation of the neighborhood iPad tablet and how to access the ASL Interpretive service. Actions taken to identify other potential residents having similar occurrences: The facility has purchased additional iPad tablets for ease of access of interpretive services (facility uses tablets for virtual interpretive services for ASL and many other languages). Facility policy Access for Communication-Impaired Residents/Patients has been revised to more clearly define the use of virtual interpretive services and use of tablets to access these services. All residents identified as communicating in a language		

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F 676	Continued From page 18 iPad interpreter. R176 indicated a concern that registered nurse (RN-D) completed a skin assessment and did not use the interpreter to communicate. R176 was upset and wheeled out to the nurse's station and pointed at RN-D. During an interview on 6/4/25 at 9:23 a.m., R176 was asked via typed communication on a computer whether the iPad interpreter in the social worker 's office had been used for care. R176 responded by shaking their head to indicate "no." They continued to communicate through written messages, stating that few staff members knew how to use the iPad interpreter but were unable to specify which staff members. During an interview on 6/4/25 at 9:30 a.m., nursing assistant (NA)-E confirmed not having ever used the iPad but was familiar with how it worked and where it was kept. During an interview on 6/4/25 at 9:40 a.m., trained medical aid (TMA)-B stated does not use the iPad to administer medications or with cares because R176 was able to answer yes or no. TMA-B stated R176 called staff and wrote down messages in a notebook. TMA-B was unaware of R176's preference, and confirmed this was the only way staff communicated with her. TMA-B confirmed not using the iPad, knowing ASL, and R176 was on her assignment sheet for the day. During an interview on 6/4/25 at 3:18 p.m., registered nurse (RN)-D stated an iPad would normally be used, but R176's skin was checked with no major concerns, the interaction wasn't a big deal. RN-D confirmed a notebook and pen was used.	F 676	other than the predominate language (English) care plans have been reviewed and revised as necessary to indicate their preferred method of communication. All staff have been trained on the facility use of virtual interpretive services and those staff that require their use to communicate with a resident have been trained on their use- location of tablets and how to access the interpretive software. Measures put in place to ensure deficient practice does not occur: For each new admit, quarterly and with any significant change to a residents communication ability, staff will inquire or review, and/or determine the residents preferred and required method of communication. Staff have been trained what signs and/or changes to monitor and communicate to the Charge Nurse of Social Worker/Social Service Coordinator assigned to a resident when their ability to understand or communicate has changed. Effective implementation of actions will be monitored by: Director of Social Services, or designee, will conduct random audits of 50% all new admissions weekly for 2 months, then 25% for 2 months for indication of their preferred method of commination and that proper care plan interventions have been implemented. Additionally, they will conduct monthly audits for all residents who have been identified as preferring or requiring an alternative method of communication for proper care plan interventions and staff use of identified communication methods. Those responsible to maintain compliance		

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F 676	Continued From page 19 During an interview on 6/5/25 at 7:06 a.m., the director of nursing (DON) stated that the care plan dictated how to communicate with the resident. The DON explained that alternative communication methods were sometimes used, and that the facility had a comprehensive policy in place for serving the deaf community. The expectation was to use the ASL interpreter for all major interactions. The DON agreed that if the resident preferred the interpreter, staff were expected to use the iPad interpreter. The DON noted that a skin assessment might not typically require use of the iPad interpreter, but given R176 ' s stated preference, it should be used. During an interview on 6/5/25 at 8:57 a.m., R176 was asked, do you prefer staff to use the iPad with all communication with you? To which R176 replied, "yes, they need education, they do not know how to use it, the social worker knows how to use it he is the only one. They think I write they have hard time reading my writing so it best to use iPad ASL it best I have to do it". Facility Access for Communication-Impaired Residents/Patients policy reviewed 8/2023, identified an interpreter be used upon request of patient/resident, explaining medication and possible side effects, and obtaining permission for treatment.			F 676	will be: Director of Social Services, or designee, will analyze the audit findings and make any needed adjustments to the facility process or policy for determining and utilizing interpretive services. They will report their findings to the Quality Assurance committee which will determine any ongoing audits. Completion date for certification purposes only is 7-18-25		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of			F 679			7/18/25

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F 679	Continued From page 20 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 2 of 4 residents (R88 and R143) reviewed for activities. Findings include: R88's quarterly Minimum Data Set (MDS) assessment dated 5/10/25, indicated R88 was admitted to the facility 2/1/25, severe cognitive impairment, sometimes feel lonely or isolated from those around, no rejection of care, wandering occurred four to six days, but less than daily, utilized a walker and wheelchair, required substantial/maximal assistance with dressing, supervision with personal hygiene, sit to lying, sit to stand, and walking, and diagnoses included hip fracture and non-Alzheimer's dementia. R88's care plan printed 6/3/25, indicated R88's leisure interests include going to church, listening to music, talking with others and watching TV and interventions included document attendance/refusals, encourage to tell staff of leisure needs, encourage short durations of activities as able, monitor activity setting for safety, place near outside edge of group, place near sound stage, provider current activity calendar. R88's Activity/Recreation Assessment dated			F 679	The preparation of the following plan of correction for this deficiency 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 deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F679 It is the policy of Lyngblomsten that based on comprehensive assessment and personal preferences each resident is provided support to engage in their choice of activities, both facility led and independent activities that meet their interests and support their physical, mental, and psycho-social well-being. To assure continued compliance the following plan has been implemented: Regarding cited residents: Resident 88 and 143 have been assessed for their activity preference and abilities to participate using the LCC Activity/Recreation Assessment. Care plans for each have been revised to reflect changes determined from the		

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F 679	Continued From page 21 4/16/25, therapeutic recreation (TR)-D director indicated activity preferences: discussion/education, food programs (baking/cooking), gardening/plants, music, reading, religious/spiritual programs, socialization, likes to talk about her family and genealogy, likes dogs and cats, family; preference for program style: small groups, 1:1, summary indicated R88 needs interaction and encouragement, visual learner, enjoy being reassured and people interaction with me in a kind way, feel best when doing something, like to laugh and enjoy funny story or joke, love to read and garden, cook, listening to music and love dogs and cats. R88's Documentation Report dated 3/1/25-3/31/25, and 4/1/25-4/30/25, indicated no documentation of R88's activities. R88's Documentation Report dated 5/1/25-5/31/25, indicated on 5/22/25 at 2:59 p.m., R88 music observed. No other documentation of activities. R88's Documentation Report dated 6/1/25-6/30/25, indicated on 6/2/25, the documentation report added 1:1 visits, independent leisure, and spiritual. On 6/2/25 at 6:38 p.m., during a telephone interview family member (FM)-E stated concern regarding the lack of available activities in the TCU (transitional care unit). FM-E stated frequent afternoon visits and had not observed R88 participate in activities. FM-E stated the TCU unit did not have activities going on for the residents. FM-E stated R88 enjoyed interaction with others and would likely participate if activities were	F 679	assessments. Actions taken to identify other potential residents having similar occurrences: Therapeutic Recreation staff have reviewed each residents activity preferences and completed the LCC Activity/Recreation Assessment as needed. Activity care plans have been updated as necessary. Therapeutic Recreation staff have been retrained on expectations for facilitating resident attendance and participation in their desired activities. Measures put in place to ensure deficient practice does not occur: The facility has developed a policy for completing the LCC Activity/Recreation Assessment and how residents are informed and invited to scheduled activities or supported in their own interests or with 1:1 activities. The facility has created an Activity task within the EHR which allows better tracking of attendance including declinations and unavailability. Additionally, Therapeutic Recreation staff have created a method to track the frequency they approach and invite residents to scheduled activities or track an individuals personal interests or when they offer/provide 1:1. Effective implementation of actions will be monitored by: The Director of Therapeutic Recreation, or designee, will be responsible to oversee the successful actions and measures developed by auditing 100% of all new admissions for completion of the LCC Activity/Recreation Assessment within the first week. Also, they will audit resident		

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F 679	Continued From page 22 offered. On 6/3/25 at 8:45 a.m., R88 was observed sleeping in bed. On 6/3/25 at 12:43 p.m., R88 was seated in a wheelchair by the first-floor nursing station and stated she wanted to go home, and further stated she like to be kept busy, specifically mentioning she enjoyed cleaning and having her fingernails painted. On 6/3/25 at 1:33 p.m., R88 was seated in a wheelchair in the day room watching television. On 6/3/25 at 1:10 p.m., trained medication aide (TMA)-D stated that each resident had an activity calendar in their room. TMA-D stated activities staff were responsible for offering activities to the residents. TMA-D stated occasionally R88 would go to chapel. On 6/3/25 at 1:13 p.m., R88's room was observed and both April 2025 and June 2025 activity calendars were found posted, April's near the door and June's behind the bedside table. Nursing Assistant (NA)-D stated that activity staff were responsible for offering activities to residents, including R88, but could not recall if R88 had participated. On 6/3/25 at 1:20 p.m., registered nurse (RN)- G stated activities staff were responsible for offering and including R88 in activities. On 6/3/25 at 1:39 p.m., TR-D stated she was responsible for first floor resident activities including R88, and stated any staff can offer and include R88 in activities. TR-D confirmed there	F 679	activity attendance weekly Those responsible to maintain compliance will be: The Director of Therapeutic Recreation will monitor audits, assuring successful completion and adjusting audit and/or processes as needed. They will report their findings to the Quality Assurance committee for continued audits. Completion date for certification purposes only is 7-18-25		

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F 679	Continued From page 23 was no documentation of R88 participating in activities prior to 6/3/25. TR-D acknowledged R88's activities were not consistently offered or documented as expected. TR-D stated she completed R88's activity interest and assessment but could not confirm those preferences were being consistently implemented On 6/4/25 at 8:18 a.m., R88 was observed in a wheelchair and self-propelled through the dining room and R88 stated she did not know what she was going to do today. On 6/4/25 at 12:58 p.m., during a follow up interview TR-D confirmed R88 was not consistently offered or included in activities and was unsure if other staff had included R88 in activities. TR-D confirmed that she was responsible for the TCU residents' activity planning and should have ensured offers were made based on R88's assessment. On 6/4/25 at 2:57 p.m., the administrator stated residents were expected to be offered activities based of interests and specific to each resident and confirmed activities staff were expected to offer and document on R88's activities. The administrator confirmed that activity offerings were expected based on the preferences and activity assessment. R143s admission MDS dated 9/16/24, identified activity preferences were books, pets, news, engaged in favorite activities, attended religious activities and going outdoors. R143's quarterly MDS dated 4/16/25, identified cognitive impairment, diagnoses of Parkinson's disease, dementia with progressive neurological conditions. R143 had clear speech, wore hearing	F 679			

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F 679	Continued From page 24 aids, had no impairment to vision, had the ability to understand others, used a walker/wheelchair and was dependent on staff for mobility/transfers. R143's care plan initiated 4/10/25, identified a care area of activities and had interventions to attend group activities and wanted encouragement to attend group programs for short periods and if unable to stay would be assisted out of the group. R143 would like his activity level monitored and assessed for changes, preferred to pursue independent activities such as having someone read devotions, bring pets to visit, walking, listening to music. The care plan identified R143 would notify activities if he needed independent leisure supplies and for staff to anticipate independent needs and to be reminded and assisted to group activities of interest. R143's paper chart that included an activities tab was reviewed but had no activities recorded. R143's electronic medical record (EMR) was reviewed but had no attendance to activities recorded. An activities assessment dated 10/25/24, identified R143's family was very involved and visited daily. He had attended some music events and was willing to stay for concerts if family attended. He enjoyed going for walks around the facility and activities of interest were animals, table games, music, singing, concerts, special events, news, devotions and worship services. R143 was a gardener and had an interest in nature groups. R143's quarterly therapeutic recreation note			F 679			

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F 679	Continued From page 25 dated 1/16/25 and 4/28/25, were reviewed and contained the same note, R143 continued to pursue independent leisure interests daily with assistance setting up as needed and participated or observed group programs as desired/able. R143's family was very involved and often visited daily. Family typically walked R143 around the neighborhood halls on 3rd floor and would at times encourage him to join activities. He had attended some music events- not a fan of polka music but more willing to stay for concerts if family attended with him. R143 used a walker for mobility and required staff/family assistance/supervision. Activities of interest include animals (had dogs), table games (risk, monopoly), music/singing/concerts (Elvis, 50's), special events, keeping up with the news, devotions and worship services (Lutheran). R143 was previously a gardener and has observed flower arrangements/nature groups when walking through the activity room with family. Independent leisure interests consist of watching tv/movies (CNN news, Netflix), visited with family, devotions, music, walking, pets, resting in my room or neighborhood lounge, and snacking as able. He often rests in the neighborhood lounge with peers where they watch tv together/ observe those passing in hallway. R143 responded to conversation and hears with loud tone and used hearing aids. His care plan has been reviewed and remained appropriate. During an interview on 6/2/25 at 12:30 p.m., family member (FM)-A stated a calendar of activities was posted in R143's room every month, but the facility doesn't invite him to attend. Most of the activities are over by the time family arrives and felt if family doesn't take him to an activity or to church, R143 sat in his room and	F 679			

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F 679	Continued From page 26 FM-A would appreciate if staff would invite him to activities. FM-A stated the few staff that came which was a long time ago, they would ask, but if he didn't respond or shook his head no, they would just leave. FM-A stated the facility had a shortage of staff and felt she needed to visit every day to take R143 out of his room. During an observation on 6/3/25 at 9:43 a.m., R143 was in the lounge area, laying in the recliner watching the news. During an observation and interview on 6/3/25 at 3:52 p.m., R143 was in the lounge area in a recliner. A privately paid companion (FM)-B stated I arrived today at 1:00 p.m., have been with R143 since he lived at home and came every Tuesday since R143 moved to the facility. FM-B stated no one from activities came today to invite R143 but the facility used to invite him to activities when he first came and confirmed no one has invited R143 to activities recently. Activity calendar for 6/3/25 read at 10:15 a.m. included devotions, 11:00 a.m. MacPhail music class, 2:00 p.m., bingo, 6:45 p.m. cloudberry choir concert. During an interview on 6/4/25 at 11:45 p.m., activities personnel (A)A stated R143 preferred to watch tv in the lounge with a small group, doesn't like large groups and therefore would not be invited to an activity such as bingo. A-A was aware R143 preferred music events but was unable to sit for long periods, so if staff brought him to an activity, he would come last. A-A acknowledged R143's wife brought him to most activities but stayed to the side. The facility didn't invite R143 as much as they should, confirmed he did not attend the music event yesterday, and that he has not attended any activity by invitation			F 679			

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F 679	Continued From page 27 recently. All activities have been with his family the past several months. During an interview on 6/4/25 at 1:18 p.m., TR-D stated the facility offered individualized activities such as an art and roving library cart, puzzles, cross words and for residents that are unable to attend large group activities we ask the nursing assistants to turn on the lounge television to view the scheduled program in a smaller group setting. Residents that need more one on one interaction could request a special friend visit or have a book read by volunteer services. Activities are tracked using point click care (computer software), but residents that decline activities were not tracked. The TR-D reviewed all R143's 2025 activity tasks reports in his EMR and confirmed no activities had been recorded. Facility Therapeutic Recreation Assessments and Documentation policy dated 5/17, indicated: Policy: To provide for official, comprehensive written records of all Resident's interests and involvement in Therapeutic Recreation programs. The Therapeutic Recreation staff are assigned the residents to which they must complete all documentation with in specified time frames. 1. Admission Assessment a. Upon admission sections Band F of the MDS will be completed and serve as the initial assessment for the resident/patient. b. A progress note which includes details of the assessment will be done c. Any corresponding raps will be completed for appropriate sections 2. Resident Care Plans a. The care plan is developed from information that is collected in the initial assessment, observations from the resident and information	F 679			

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F 679	Continued From page 28 obtained from their representative. b. A care plan will be developed for each resident/patient within 21 days c. Care Plan will be reviewed and updated as needed every 90 days, if a significant change occurs and as needed. 3. Daily Attendance Records a. Daily attendance will be recorded in POC b. Review records every 90 days, if a significant change occurs and as needed to ensure any emerging needs for resident / patient reassessments or care plan reviews. c. File attendance records for a minimum of 5 years d. Make use of attendance records as data for summary within resident /patient progress notes 4. Quarterly/Annual/ Significant Change Progress Notes a. Summarize information from activities, care plan and MDS assessments to complete quarterly progress note. b. Do a Therapeutic Recreation Progress note.	F 679			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess transfers with a mechanical lift or develop	F 689	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted		7/18/25

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F 689	Continued From page 29 and implement policies to ensure the safety and supervision for 1 of 4 residents (R20) reviewed for accidents. Findings include: R20's annual Minimum Data Set (MDS) assessment dated 4/2/25, identified severely impaired cognition and had limited function to the right arm and hand, used a wheelchair, required maximal assistance for mobility and was on hospice. R20's diagnoses included cerebral palsy, seizure and psychotic disorders, and post-polio syndrome. R20's care plan (CP) created on 6/2/23, identified mobility as an area of concern and indicated one staff assisted with bed mobility, repositioning, and sitting up. Furthermore, the CP identified R20 had a history of compression fractures to the spine and spasticity/hemiparesis of the right hand since birth, was not ambulatory and needed one to two staff for transfers with the mechanical lift (EZ Stand). R20's electronic medical record (EMR) contained a completed annual physical device evaluation dated 3/3/25 but failed to reassess R20's transfer needs when a mechanical lift was used. During an observation and interview on 6/2/25 at 4:51?p.m., R20 was found in bed with the upper body against the wall, the head resting against the wall at an angle, and the left foot hanging off the bed while calling out for help. Licensed practical nurse (LPN) B entered the room and repositioned R20. R20 was moved into a seated position, a belt was placed around the resident and attached to the mechanical standing lift; both	F 689	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F689 It is the policy of Lyngblomsten that each resident receives adequate supervision and necessary assistance devices to prevent accidents. To assure continued compliance the following plan has been implemented: Regarding cited residents: Resident 20s transfer status has been updated to reflect the need for full mechanical lift to transfer. Actions taken to identify other potential residents having similar occurrences: All residents transfer status has been reviewed and revised if necessary. Staff responsible for transferring residents have been re-trained on facility transfer policy and procedures, including when and how to communicate resident changes that would indicate a transfer status assessment is necessary. Measures put in place to ensure deficient practice does not occur: Facility policies; Transfer Procedure and Resident Transfer Ability Assessment and Reassessment have been reviewed and several revisions were made. Facility developed and implemented LCC Transfer Assessment in Point Click Care-		

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F 689	Continued From page 30 feet were lifted onto the foot plate by the nurse. R20's left hand was placed on the handle and held securely by a nursing assistant (NA)-C. R20's right arm was flaccid and hung down at the side of the body. R20 was observed hanging from the stand, unable to bear weight while being lowered onto the wheelchair. LPN B stated that R20's mode of transfer was by the mechanical standing lift and the criteria to use the lift was to bare weight and at least one hand on the handle, then stated R20 met criteria for a standing lift. During an interview on 6/3/25 at 9:15 a.m., NA-A stated I am not comfortable with R20's transfers and called for a second aid. NA-A stated the standing lift was appropriate for R20 because he stood up good and held on to the handle with one hand. During an observation and interview on 6/3/25 at 9:25 a.m., NA-A and NA-C assisted R20 transfer using the mechanical standing lift. R20's left hand was secured to the handle, but R20 did not stand up independently, could not bear weight and hung from the lift. NA-A stated R20 supported himself during other transfers and would often stand without hanging on and needed reminders to hang on before the aids would start the transfer. During an interview on 6/3/25 at 1:35 p.m., director of therapy (DOT) stated therapy assessed residents for transfers upon admission, status change, or if a referral was received. The DOT stated R20 was not currently in therapy and was unfamiliar with the transfers. The qualifications to use the EZ Stand (mechanical standing lift) would be to bear weight, moderate to maximal assistant, tolerated standing at least			F 689	facility EHR. Those staff responsible for assessing transfer abilities have been trained on the use of the new assessment, including when the assessment is to be completed. Effective implementation of actions will be monitored by: Nursing Administration will conduct audits of 100% LCC Transfer Assessment assessments- completed weekly for 1 month, then 50% for 2 months. Additionally, nursing administration will conduct 5 random observational audits of stand assist transfers per week for 1 month, with continued observational audits as needed. Those responsible to maintain compliance will be: Director of Nursing, or designee will monitor audit schedule and findings and adjust as needed. Audit findings will be reported to Quality Assurance committee which will determine any going monitoring. Completion date for certification purposes only is 7-18-25		

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F 689	Continued From page 31 thirty seconds, and to hold on with one hand decently. The DOT stated patients with hemiparesis, for example a stroke patient would not be a candidate for the EZ Stand. The DOT stated resident needed to assist with the stand to use the EZ Stand and confirmed therapy has not received a referral to assess transfers for R20 but would observe a transfer later today. During an interview on 6/3/25 at 1:50 p.m., licensed practical nurse (LPN)-A explained the process on how residents are assessed for transfers. It starts with new admissions, physical and occupational therapy (PT, OT) provided guidance, the resident and family's goals and fears are discussed and overall allowed the residents to function at their highest level but remained safe. LPN-A stated if there was a change in transfer abilities a referral was placed to PT for an evaluation and the criteria used for the EZ Stand was to bear weight. If a resident had a stroke, two assistants were required. LPN-A stated the nursing assistants kept the nurse updated on transfers, but ultimately it was the nurse's decision and if there was a concern after the evaluation the resident would use the next level for transfers. LPN-A stated staff were aware of the process. During an observation and interview on 6/3/25 at 3:33 p.m., NA-B and NA-C entered R20's room and began to transfer R20 with the standing lift. The DOT observed the transfer. NA-B and NA-C indicated they were familiar with R20 and abilities to transfer. R20's legs were dependent upon staff to lift them on to the foot plate, the belt was attached to R20's waist, left hand placed on the handle, and right arm hung to the side in a flaccid position. The DOT asked how long R20 could			F 689			

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F 689	Continued From page 32 stand and then R20's left hand fell from the handle. NA-C asked the DOT if this meant R20 could not safely transfer with the EZ Stand and the DOT nodded yes. The DOT stated EZ Stand transfers needed 20 some seconds of tolerance, but usually 45-60 seconds was needed to transfer to the wheelchair or toilet and then confirmed R20 should no longer use the EZ Stand. During an interview on 6/4/25 at 3:52 p.m., the director of nursing (DON) stated the process for transfers was continuous monitoring of care needs and adjusted transfer abilities based on the front-line staff recommendations. Any changes are discussed, care planned, and it was a collaborate effort based on a formal assessment from therapy. The DON stated the staff knew how to transfer resident safely and are saying the correct things but had learned that staff didn't identify unsafe transfers. Facility Transfer Procedures policy revised 5/24, identified residents are not suited for standing transfers are unpredictably able to bear weight, unable to hold onto handles/lift frame. Facility Physical Device Evaluations policy revised 6/22, identified evaluations for any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The guidelines identified an atypical method, or device is considered any intervention or equipment that is nonroutine or would not be considered standard or required in the normal delivery of care. Some examples of atypical methods or devices are geri-chairs, wedge cushion in	F 689			

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F 689	Continued From page 33			F 689			
F 760 SS=D	wheelchairs, bed placed against a wall for purposes other than room décor/style, anti-roll back wheelchairs. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 6 residents (R115) reviewed for medication administration. Findings include: R115's face sheet printed 6/5/25, indicated diagnoses of reduced mobility, cardiac pacemaker, personal history of sudden cardiac arrest, Alzheimer's disease, and heart failure. R115's quarterly Minimum Data Set (MDS) assessment dated 5/7/25, indicated moderately impaired cognition, use of wheelchair, substantial/maximal assistance with personal hygiene, lower body dressing, and bathing. R115's care plan printed revised 8/14/24, indicated self-care deficit related to congestive heart failure, pacemaker in left chest, and dementia. Staff crush my pills, mix together in applesauce to aide in swallowing. R115's physician's orders printed 6/5/25, indicated an order for metoprolol succinate			F 760			7/18/25

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F 760	Continued From page 34 extended release 50mg tablet (blood pressure medication) daily for high blood pressure. An additional order stated medications may be crushed or given in liquid form unless contraindicated or otherwise. During observation on 6/4/25 at 8:30 a.m., trained medication aide (TMA)-C prepared medications for administration to R115. TMA-C crushed acetaminophen 1000mg, metoprolol 50mg extended release, potassium 20meq, torsemide 30mg, and sertraline 100mg for ease of swallowing for R115. During interview on 6/4/25 at 8:35 a.m., prior to administration of medication to R115, TMA-C verified she had been crushing R115's metoprolol succinate extended-release tablet for quite some time due to R115's difficulty swallowing multiple pills and intended to administer metoprolol succinate tablet crushed. TMA-C further stated R115 had an order to crush medications so she assumed metoprolol succinate extended release could be crushed. TMA-C stated she did not see the green sticker on the metoprolol succinate extended-release medication card that read: do not crush or chew. During interview on 6/4/25 at 8:45 a.m., registered nurse (RN)-E stated R115 had an order to crush medications. RN-E further stated she was unsure if the metoprolol succinate extended-release could be crushed and she would need to call the provider to check. RN-E stated she did not know the metoprolol succinate extended-release medication card included a sticker indicating not to crush or chew the medication.			F 760	Actions taken to identify other potential residents having similar occurrences: All residents with orders to crush medications have been reviewed. All have been converted to new templating process which makes it clear in the EMAR what medications can be crushed. Other medication crush orders requiring additional changes have been updated. Measures put in place to ensure deficient practice does not occur: Staff responsible for administering medications have been re-trained on medications that can/cannot be crushed and how crush orders are communicated via the EHR. Order entry process for crushed medications which helps identify crushable medications via the EMAR developed and all existing medications have been converted to new method. All staff responsible for entering medication administration orders have been trained on the new process. Effective implementation of actions will be monitored by: Nursing Administration will conduct audits of all crush medication orders completed for 1 month, then 50% of orders for 1 month. Additionally, nursing administration will conduct 5 random observational audits per week for 1 month, with continued observational audits completed as needed. Those responsible to maintain compliance will be: The Director of Nursing, or designee will monitor the actions and measures implemented and review audits findings. Director of Nursing will adjust process		

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F 760	Continued From page 35 During interview on 6/4/25 at 9:15 a.m., RN-E stated she had called nurse practitioner (NP)-D and NP-D stated the metoprolol succinate extended-release could not be crushed. NP-D changed the order to metoprolol tartrate 25mg tablet two times per day. During interview on 6/5/25 at 8:39 a.m. director of nursing (DON) stated he had heard about this medication error yesterday and had informed RN-E that extended-release medications could not be crushed unless specifically ordered by a provider due to them needing to be released in the body over time. DON further stated it was the facility's responsibility to make sure the provider was notified if a medication needed to be changed to a different form to be crushed and he would expect the nurses to do that. R115's blood pressure readings were reviewed for one month and ranged from 117/75 to 157/86. A facility policy on crushing of medications was requested but not received.	F 760	changes as needed based on audit findings. Audit findings and any process adjustments made will be reported to the Quality Assurance committee for ongoing auditing. Completion date for certification purposes only is 7-18-25		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/03/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lyngblomsten Care Center, was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/09/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Lyngblomsten Care Center is a 4-story building with a full basement. The building was constructed at two 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 Southside that was determined to be of Type II(222) construction. Because the original building and the one addition are of the same type of construction, the facility was surveyed as one			K 000			

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K 000	Continued From page 2 building.	K 000			
K 200 SS=F	The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 225 beds and had a census of 210 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview the facility was not following the applicable NFPA 101 and NFPA 80, 5.2.3.5.2, for testing and inspecting of the facility fire doors. This deficient finding could have a widespread impact on the residents.	K 200	To meet the requirements of testing and inspecting of facility fire doors per NFPA 101 & NFPA 80, 5.2.3.5.2, Physical Plant staff will test, inspect fire doors and document same. Physical Plant Director will audit annually for compliance.	7/18/25	

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

PRINTED: 07/09/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245347		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/03/2025	
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 200	Continued From page 3 Findings include: On 06/03/2025, at 10:12 AM, by review of the available documentation at the time of the survey, there was no fire door inspection report available for review.			K 200			
K 222 SS=F	An interview with the Maintenance Director verified this deficient finding. Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler			K 222			6/13/25

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K 222	Continued From page 4 system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the proper operation of exit door locking device system per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1. This deficient finding could have a	K 222	To meet requirements of maintaining proper operation of exit door locking device system per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.6.1.1, the Physical Plant staff will		

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NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108		
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K 222	Continued From page 5 widespread impact on the residents within the facility. Findings include: On 06/03/2025 at 10:50 AM, it was revealed by observation the Fire Doors by the NE Stair on the 3rd floor and the Doors to 2 E failed to latch when tested. An interview with Maintenance Director verified this deficient finding at the time of discovery	K 222	repair Latches on Fire Doors by the NE Stair on the 3rd floor and the doors to 2 E. Physical Plant Director will verify and audit annually for compliance.		
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3 and failed to maintain the Gas and Utility System per NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2. This deficient finding could have a patterned impact on the residents within	K 511	To meet the requirements of securing electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3, NFPA 101 (2012 edition), Life Safety Code section 9.2.2 and NFPA 54 (2012 edition), National Fuel Gas Code, sections 9.2.2 and 10.3.2.2, Physical Plant staff will replace lock and secure electrical panel in room 278.	6/18/25	

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NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108		
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K 511	Continued From page 6 the facility. Findings include: On 06/03/2025, at 11:10 AM, it was revealed by observation that the electrical panel at room 278 was unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 511	Physical Plant Director will verify and monitor for continued compliance on a periodic basis.		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 521	To meet the requirements of inspecting fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12, Physical Plant Director obtained contract with HVAC contractor to inspect fire dampers. Physical Plant Director will audit for compliance every four years. CMS-2786R waiver submitted	7/9/25	

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K 521	Continued From page 7 On 06/03/2025 at 10:00, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the dampers in the facility had been inspected within four years.	K 521			
K 918 SS=F	An interview with the Maintenance Director verified this deficient finding at the time of discovery. Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		6/23/25	

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K 918	Continued From page 8 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.4.1, and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/03/2025 at 10:10 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that weekly generator inspections had occurred. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K 918	To meet the requirements of maintaining the emergency generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 8.3.4, 8.4.1, and 8.4.2, Physical Plant staff will date, with year, revised form when performing weekly generator inspections. Physical Plant Director will audit weekly for compliance.		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245347	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 6/3/2025
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 351	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install sprinkler heads per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1 and 9.7.1.1 and NFPA 13 (2010 edition), The Standard for the Installation of Sprinkler Systems, sections 8.1.1, 8.3.2.5, 8.4.9.1 and 8.4.9.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/03/2025, at 10:22 AM, it was revealed by observation that there were wires in contact with the sprinkler system in the Tunnel. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			
	K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.1.1, 7.2, 7.2.1.2, 7.2.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include:		

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245347	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 6/3/2025
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 355	Continued From Page 1			
K 923	On 06/03/2025 at 10:20 AM, it was revealed by observation, that there were fire extinguishers in Storage Room 17 that were free standing and unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			
	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.6.5. This deficient finding could have am isolated impact on the residents within the facility. Findings include: On 06/03/2025 at 10:15 AM, it was revealed by observation that in the Maintenance Shop, there were compressed gas cylinders that were on a shelf unsecured. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245347	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 6/3/2025
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 923	Continued From Page 2			

PART III – RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety Code recommended for waiver, list the survey report form item number and state the reason for the conclusion that:
(a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)

JUSTIFICATION

K521 Failure to Inspect Fire Damper	Once we were made aware we were out of compliance we reached out to our vendor, Nasseff, for the first available appointment. Even with our urgent request, they were unable to send a crew to our location to complete the inspection until mid-August 2025. They told us to anticipate 1-month for completion of our fire damper inspection which would be mid-September, 2025. We are a fully monitored, alarmed and sprinkled building. Our staff are aware we are awaiting inspection of the dampers and will report any out of the ordinary circumstances immediately. Completion Date: 9/18/25
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Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature) Travis J. Ahrens 49207	Title Fire Safety Supervisor	Office MN State Fire Marshal Div.	Date 7/8/25



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 30, 2025

Administrator
Lyngblomsten Care Center
1415 Almond Avenue
Saint Paul, MN 55108

Re: State Nursing Home Licensing Orders
Event ID: 3FKO11

Dear Administrator:

The above facility was surveyed on June 2, 2025 through June 5, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00501	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2025
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/2/25-6/5/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

07/09/25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00501	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/05/2025
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed and NO citations were issued. H53475950C (MN00113419) H53476007C (MN00110334) H53476008C (MN00107630) H53476009C (MN00110666) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the	2 000			

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2 000	Continued From page 2 Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000			
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure freedom of movement was not restricted for 1 of 1 resident (R143) who was reviewed for physical restraints. Findings include:	2 530	Corrected	7/18/25	

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2 530	Continued From page 3 R143's quarterly Minimum Data Set (MDS) assessment, dated 4/16/25, identified severely impaired cognition. R143's diagnoses included; Parkinson's disease (a chronic progressive neurological disorder), dementia, and progressive neurological conditions accompanied by a psychotic disorder. R143 required maximum assistance to ambulate ten feet and was fully dependent on others when using the wheelchair. They also needed maximal assistance for transfers, including rolling from side to side, seating, and positioning in bed. A bed alarm was used daily. R143's care plan reviewed on 4/10/25, identified interventions for self care deficits, fall risk, and mood enhancement. The interventions included placing the resident in the common area recliner to engage in activities-such as watching the news-and for staff to observe and intervene when R143 attempted to self transfer. Staff were encouraged to keep R143 in public areas whenever not eating or napping. Furthermore, the care plan recognized impaired mobility secondary to impaired balance and unsteady gait. R143 required assistance from two staff members with a walker; one to two staff for bed mobility, repositioning, sitting up, and rolling side to side; and that a mechanical lift was used when R143 became stiff. R143 was able to propel self short distances but needed assistance for longer distances or when off the unit. R143's active providers orders last reviewed 5/6/25, identified a pressure alarm and pads but lacked an order for restraints. R143's quarterly Interdisciplinary Care Conference report dated 4/28/25, identified family	2 530			

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2 530	Continued From page 4 member (FM)-A attended the conference and requested the television on when R143 was in the lounge area and recommended which channels were preferred and suggested R143 held a book for comfort. R143's progress notes dated 5/10/25 at 1:55 p.m., indicated R143 had more than one fall in the past three months, had balance and decreased muscular coordination and used medications that placed R143 at moderate risk for falls. R143's progress notes dated 5/16/25 at 6:33 p.m., indicated R143 was screened by occupational therapy (OT) post fall, was not a candidate for OT due to the lack of following directions and declined in basic activities of daily living (BADL) and needed extensive assist since admission despite therapy intervention. R143's progress notes dated 5/31/25 at 6:12 p.m., indicated R143 self-transferred and was seen walking around his room unassisted and indicated R143 was not stable walking on his own and brought out to the nurse's station for one-on-one cares. R143's electronic medical record (EMR) lacked documentation for a medical diagnosis treated by use of the electric recliner. Furthermore, the medical record failed to show an assessment or R143's ability to rise independently out of the chair/recliner. During an interview on 6/2/25 at 12:30 p.m., FM-A stated staff placed R143 in the common area in the chair, reclined, with his feet up because the bed alarm can no longer be used. The recliner was the only place staff could keep him because	2 530			

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2 530	Continued From page 5 of the recent falls. During an observation on 6/3/25 at 3:52 p.m., R143 was in the common area, in a recliner with both feet up. The recliner remote was hung over the back of the chair. R143's personal paid companion was seated to the right and two other residents were in their wheelchairs. No staff were present. During an interview on 6/4/25 at 8:54 a.m., registered nurse (RN)-C stated R143 can't activate the chair, and the wife requested the use of the recliner. RN-C further stated any assessment would be done by OT and was not aware of any completed assessment. During an observation on 6/4/25 at 9:54 a.m., R143 was in the recliner in the common area, both feet were up. R143 was awake and looking around the room. The remote was placed arms reach away on the heat register. During an interview 6/4/25 at 11:42 a.m., FM-A stated no consent, or waiver was signed that approved the use of the recliner. During an interview on 6/4/25 at 11:46 a.m., director of therapy (DOT) stated R143 had been assessed for transfers, but never assessed for a recliner. During an interview on 6/4/25 at 11:46 a.m., the director of therapy (DOT) stated R143 was assessed for transfers only and never assessed for safety with the use of an electric recliner. The DOT was not aware of any assessments ever completed for a lift chair or recliner. During an Interview on 6/5/25 at 7:09 a.m., the	2 530			

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2 530	Continued From page 6 director of nursing (DON) stated he confirmed with the nurse manager on the unit that R143 cannot get up from the recliner, but felt the recliner was a safe intervention and now staff could observe and intervene as he is in the lobby and not in his room. During an interview on 6/5/25 at 8:29 a.m., occupational therapy (OT)-A confirmed no referral was received to assess the safety and use of the electric recliner for R143 furthermore, an assessment would be requested for a recliner only if a pressure injury occurred that required a cushion or if a resident had fallen out of a recliner. OT-A was aware of assessments for recliners and completed those at other facilities, then confirmed R143 had not been assessed to use the recliner. Restraint Use policy revised 5/21, identified the use of physical restraint was prohibited for discipline or convenience, unnecessarily inhibit a resident's freedom of movement or activity. Convenience was defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest. "Freedom of movement" means any change in place or position for the body or any part of the body that the person is physically able to control. "Physical Restraint" is defined as any manual method, physical or mechanical device, equipment, or material that meets all the following criteria: is attached or adjacent to the resident's body, cannot be removed easily by the resident, restricts the resident's freedom of movement or normal access to his/her body. Physical Device Evaluations policy revised 6/22,	2 530			

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2 530	Continued From page 7 identified evaluations for any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The guidelines identified an atypical method, or device is considered any intervention or equipment that is nonroutine or would not be considered standard or required in the normal delivery of care. Some examples of atypical methods or devices are Geri-chairs, wedge cushion in wheelchairs, bed placed against a wall for purposes other than room décor/style, anti-roll back wheelchairs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures; then inservice staff regarding conducting a comprehensive physical restraint assessment prior to initiating any physical devices intended to stop resident movement. The DON could then audit to ensure compliance. The audit audits could be taken to the quality assurance performance improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 530			
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment.	2 550			7/18/25

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2 550	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect discharge status for 1 of 1 resident (R200) reviewed for hospitalization. Findings include: R200's discharge Minimum Data Set (MDS) dated 3/6/25, indicated R200 admitted to facility on 2/10/25, from a Short-Term General Hospital, and discharged from facility on 3/6/25, discharging to Short-Term General Hospital. R200's progress note dated 3/5/25 at 10:00 a.m., indicted R200 discharge home back to [name of assisted living] signed onto hospice so no home services. R200's nursing progress note dated 3/6/25 at 11:04 a.m., indicated R200 discharged to [name of assisted living]. On 6/4/25 at 10:05 a.m., registered nurse (RN)-F, know as a MDS coordinator reviewed R200's MDS dated 3/6/25, and confirmed the MDS was inaccurately coded and R200 discharged home and not to the hospital. RN-F stated the MDS was expected coded correctly and correction would need to be completed. On 6/4/25 at 2:49 p.m., the director of nursing (DON) stated the MDS was expected to be accurate and the MDS coordinators follow the MDS RAI (Resident Assessment Instrument) manual.	2 550	Corrected		

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2 550	Continued From page 9 Long-Term Care Facility Resident Assessment Instrument 3.0 User ' s Manual dated 10/24, indicated In addition, an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations. Those sources must include the resident and direct care staff on all shifts, and should also include the resident ' s medical record, physician, and family, guardian and/or other legally authorized representative, or significant other as appropriate or acceptable. It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident ' s actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS)assessments and the collection of required information. The DON or designee could educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. The results of those audits could be taken to the quality assurance performance improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550			

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess transfers with a mechanical lift or develop and implement policies to ensure the safety and supervision for 1 of 4 residents (R20) reviewed for accidents. Findings include: R20's annual Minimum Data Set (MDS) assessment dated 4/2/25, identified severely impaired cognition and had limited function to the right arm and hand, used a wheelchair, required maximal assistance for mobility and was on hospice. R20's diagnoses included cerebral palsy, seizure and psychotic disorders, and post-polio syndrome. R20's care plan (CP) created on 6/2/23, identified mobility as an area of concern and indicated one	2 830	Corrected	7/18/25	

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2 830	Continued From page 11 staff assisted with bed mobility, repositioning, and sitting up. Furthermore, the CP identified R20 had a history of compression fractures to the spine and spasticity/hemiparesis of the right hand since birth, was not ambulatory and needed one to two staff for transfers with the mechanical lift (EZ Stand). R20's electronic medical record (EMR) contained a completed annual physical device evaluation dated 3/3/25 but failed to reassess R20's transfer needs when a mechanical lift was used. During an observation and interview on 6/2/25 at 4:51?p.m., R20 was found in bed with the upper body against the wall, the head resting against the wall at an angle, and the left foot hanging off the bed while calling out for help. Licensed practical nurse (LPN) B entered the room and repositioned R20. R20 was moved into a seated position, a belt was placed around the resident and attached to the mechanical standing lift; both feet were lifted onto the foot plate by the nurse. R20's left hand was placed on the handle and held securely by a nursing assistant (NA)-C. R20's right arm was flaccid and hung down at the side of the body. R20 was observed hanging from the stand, unable to bear weight while being lowered onto the wheelchair. LPN B stated that R20's mode of transfer was by the mechanical standing lift and the criteria to use the lift was to bare weight and at least one hand on the handle, then stated R20 met criteria for a standing lift. During an interview on 6/3/25 at 9:15 a.m., NA-A stated I am not comfortable with R20's transfers and called for a second aid. NA-A stated the standing lift was appropriate for R20 because he stood up good and held on to the handle with one hand.	2 830			

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2 830	Continued From page 12 During an observation and interview on 6/3/25 at 9:25 a.m., NA-A and NA-C assisted R20 transfer using the mechanical standing lift. R20's left hand was secured to the handle, but R20 did not stand up independently, could not bear weight and hung from the lift. NA-A stated R20 supported himself during other transfers and would often stand without hanging on and needed reminders to hang on before the aids would start the transfer. During an interview on 6/3/25 at 1:35 p.m., director of therapy (DOT) stated therapy assessed residents for transfers upon admission, status change, or if a referral was received. The DOT stated R20 was not currently in therapy and was unfamiliar with the transfers. The qualifications to use the EZ Stand (mechanical standing lift) would be to bear weight, moderate to maximal assistant, tolerated standing at least thirty seconds, and to hold on with one hand decently. The DOT stated patients with hemiparesis, for example a stroke patient would not be a candidate for the EZ Stand. The DOT stated resident needed to assist with the stand to use the EZ Stand and confirmed therapy has not received a referral to assess transfers for R20 but would observe a transfer later today. During an interview on 6/3/25 at 1:50 p.m., licensed practical nurse (LPN)-A explained the process on how residents are assessed for transfers. It starts with new admissions, physical and occupational therapy (PT, OT) provided guidance, the resident and family's goals and fears are discussed and overall allowed the residents to function at their highest level but remained safe. LPN-A stated if there was a change in transfer abilities a referral was placed	2 830			

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2 830	Continued From page 13 to PT for an evaluation and the criteria used for the EZ Stand was to bear weight. If a resident had a stroke, two assistants were required. LPN-A stated the nursing assistants kept the nurse updated on transfers, but ultimately it was the nurse's decision and if there was a concern after the evaluation the resident would use the next level for transfers. LPN-A stated staff were aware of the process. During an observation and interview on 6/3/25 at 3:33 p.m., NA-B and NA-C entered R20's room and began to transfer R20 with the standing lift. The DOT observed the transfer. NA-B and NA-C indicated they were familiar with R20 and abilities to transfer. R20's legs were dependent upon staff to lift them on to the foot plate, the belt was attached to R20's waist, left hand placed on the handle, and right arm hung to the side in a flaccid position. The DOT asked how long R20 could stand and then R20's left hand fell from the handle. NA-C asked the DOT if this meant R20 could not safely transfer with the EZ Stand and the DOT nodded yes. The DOT stated EZ Stand transfers needed 20 some seconds of tolerance, but usually 45-60 seconds was needed to transfer to the wheelchair or toilet and then confirmed R20 should no longer use the EZ Stand. During an interview on 6/4/25 at 3:52 p.m., the director of nursing (DON) stated the process for transfers was continuous monitoring of care needs and adjusted transfer abilities based on the front-line staff recommendations. Any changes are discussed, care planned, and it was a collaborate effort based on a formal assessment from therapy. The DON stated the staff knew how to transfer resident safely and are saying the correct things but had learned that staff didn't identify unsafe transfers.	2 830			

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2 830	Continued From page 14 Facility Transfer Procedures policy revised 5/24, identified residents are not suited for standing transfers are unpredictably able to bear weight, unable to hold onto handles/lift frame. Facility Physical Device Evaluations policy revised 6/22, identified evaluations for any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The guidelines identified an atypical method, or device is considered any intervention or equipment that is nonroutine or would not be considered standard or required in the normal delivery of care. Some examples of atypical methods or devices are geri-chairs, wedge cushion in wheelchairs, bed placed against a wall for purposes other than room décor/style, anti-roll back wheelchairs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review policies and procedures and re-educate staff on the proper use of mechanical lifts/slings according to the manufactures safety instructions. The DON or designees could conduct periodic audits, request PT/OT assessments on mechanical lifts/electric chairs/recliners to ensure ongoing compliance and safety with their use or any other adaptive devices. The DON could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensuer ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830			

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2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently utilize a communication device or provide an interpreter for 1 of 1 resident (176) reviewed who was deaf and used ASL to communicate care needs. Findings Include: R176's significant change Minimum Data Set (MDS) assessment dated 4/17/25, identified no cognitive impairment, primary language was American sign language (ASL), and an interpreter was needed to communicate with doctors and health care staff.	2 915	Corrected	7/18/25	

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2 915	Continued From page 16 R176's care plan revised on 12/3/24, identified impaired communication. R176's care plan identified methods for communicating such as short, direct simple phrases, visual aids, and indicated please provide me with an ASL interpreter for all significant meetings/interactions such as care conferences, cognitive/mood assessments, etc. R176's active provider orders last reviewed 5/5/25, indicated weekly pain and skin assessments, daily ambulation program and a fluid restriction order which could have required staff to communicate with R176. During an initial interview on 6/2/25 at 1:11 p.m., R176 wrote on a notebook, some of the staff do not know how to use the iPad to contact the ASL interpreter and wrote on a notebook to communicate. R176 wrote my preference was the ASL interpreter be used with all cares because writing in ASL structure confuses staff that are non-English speaking. An ASL Interpreter was used for the remainder of the interview and through the interpreter R176 expressed concerns that aids and nurses do not understand me and it has always been my preference to use the ASL interpreter. During an interview on 6/3/25 at 4:00 p.m., R176 typed on a word document that staff did not use the iPad interpreter with any interactions or cares today and that only the social worker used the iPad interpreter. R176 indicated a concern that registered nurse (RN-D) completed a skin assessment and did not use the interpreter to communicate. R176 was upset and wheeled out to the nurse's station and pointed at RN-D. During an interview on 6/4/25 at 9:23 a.m., R176	2 915			

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2 915	Continued From page 17 was asked via typed communication on a computer whether the iPad interpreter in the social worker ' s office had been used for care. R176 responded by shaking their head to indicate "no." They continued to communicate through written messages, stating that few staff members knew how to use the iPad interpreter but were unable to specify which staff members. During an interview on 6/4/25 at 9:30 a.m., nursing assistant (NA)-E confirmed not having ever used the iPad but was familiar with how it worked and where it was kept. During an interview on 6/4/25 at 9:40 a.m., trained medical aid (TMA)-B stated does not use the iPad to administer medications or with cares because R176 was able to answer yes or no. TMA-B stated R176 called staff and wrote down messages in a notebook. TMA-B was unaware of R176's preference, and confirmed this was the only way staff communicated with her. TMA-B confirmed not using the iPad, knowing ASL, and R176 was on her assignment sheet for the day. During an interview on 6/4/25 at 3:18 p.m., registered nurse (RN)-D stated an iPad would normally be used, but R176's skin was checked with no major concerns, the interaction wasn't a big deal. RN-D confirmed a notebook and pen was used. During an interview on 6/5/25 at 7:06 a.m., the director of nursing (DON) stated that the care plan dictated how to communicate with the resident. The DON explained that alternative communication methods were sometimes used, and that the facility had a comprehensive policy in place for serving the deaf community. The expectation was to use the ASL interpreter for all	2 915			

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2 915	Continued From page 18 major interactions. The DON agreed that if the resident preferred the interpreter, staff were expected to use the iPad interpreter. The DON noted that a skin assessment might not typically require use of the iPad interpreter, but given R176 ' s stated preference, it should be used. During an interview on 6/5/25 at 8:57 a.m., R176 was asked, do you prefer staff to use the iPad with all communication with you? To which R176 replied, "yes, they need education, they do not know how to use it, the social worker knows how to use it he is the only one. They think I write they have hard time reading my writing so it best to use iPad ASL it best I have to do it". Facility Access for Communication-Impaired Residents/Patients policy reviewed 8/2023, identified an interpreter be used upon request of patient/resident, explaining medication and possible side effects, and obtaining permission for treatment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable polices and procedures pertaining to completion of resident communication preferences; then inservice direct care staff on such procedures and audit to ensure ongoing compliance. The facility could report the findings of these audits to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915			

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21435	Continued From page 19	21435			7/18/25
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 2 of 4 residents (R88 and R143) reviewed for activities. Findings include: R88's quarterly Minimum Data Set (MDS) assessment dated 5/10/25, indicated R88 was admitted to the facility 2/1/25, severe cognitive impairment, sometimes feel lonely or isolated from those around, no rejection of care, wandering occurred four to six days, but less than daily, utilized a walker and wheelchair, required substantial/maximal assistance with dressing, supervision with personal hygiene, sit to lying, sit to stand, and walking, and diagnoses included hip fracture and non-Alzheimer's dementia. R88's care plan printed 6/3/25, indicated R88's				

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21435	Continued From page 20 leisure interests include going to church, listening to music, talking with others and watching TV and interventions included document attendance/refusals, encourage to tell staff of leisure needs, encourage short durations of activities as able, monitor activity setting for safety, place near outside edge of group, place near sound stage, provider current activity calendar. R88's Activity/Recreation Assessment dated 4/16/25, therapeutic recreation (TR)-D director indicated activity preferences: discussion/education, food programs (baking/cooking), gardening/plants, music, reading, religious/spiritual programs, socialization, likes to talk about her family and genealogy, likes dogs and cats, family; preference for program style: small groups, 1:1, summary indicated R88 needs interaction and encouragement, visual learner, enjoy being reassured and people interaction with me in a kind way, feel best when doing something, like to laugh and enjoy funny story or joke, love to read and garden, cook, listening to music and love dogs and cats. R88's Documentation Report dated 3/1/25-3/31/25, and 4/1/25-4/30/25, indicated no documentation of R88's activities. R88's Documentation Report dated 5/1/25-5/31/25, indicated on 5/22/25 at 2:59 p.m., R88 music observed. No other documentation of activities. R88's Documentation Report dated 6/1/25-6/30/25, indicated on 6/2/25, the documentation report added 1:1 visits, independent leisure, and spiritual.	21435			

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21435	Continued From page 21 On 6/2/25 at 6:38 p.m., during a telephone interview family member (FM)-E stated concern regarding the lack of available activities in the TCU (transitional care unit). FM-E stated frequent afternoon visits and had not observed R88 participate in activities. FM-E stated the TCU unit did not have activities going on for the residents. FM-E stated R88 enjoyed interaction with others and would likely participate if activities were offered. On 6/3/25 at 8:45 a.m., R88 was observed sleeping in bed. On 6/3/25 at 12:43 p.m., R88 was seated in a wheelchair by the first-floor nursing station and stated she wanted to go home, and further stated she like to be kept busy, specifically mentioning she enjoyed cleaning and having her fingernails painted. On 6/3/25 at 1:33 p.m., R88 was seated in a wheelchair in the day room watching television. On 6/3/25 at 1:10 p.m., trained medication aide (TMA)-D stated that each resident had an activity calendar in their room. TMA-D stated activities staff were responsible for offering activities to the residents. TMA-D stated occasionally R88 would go to chapel. On 6/3/25 at 1:13 p.m., R88's room was observed and both April 2025 and June 2025 activity calendars were found posted, April's near the door and June's behind the bedside table. Nursing Assistant (NA)-D stated that activity staff were responsible for offering activities to residents, including R88, but could not recall if R88 had participated.	21435			

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21435	Continued From page 22 On 6/3/25 at 1:20 p.m., registered nurse (RN)- G stated activities staff were responsible for offering and including R88 in activities. On 6/3/25 at 1:39 p.m., TR-D stated she was responsible for first floor resident activities including R88, and stated any staff can offer and include R88 in activities. TR-D confirmed there was no documentation of R88 participating in activities prior to 6/3/25. TR-D acknowledged R88's activities were not consistently offered or documented as expected. TR-D stated she completed R88's activity interest and assessment but could not confirm those preferences were being consistently implemented On 6/4/25 at 8:18 a.m., R88 was observed in a wheelchair and self-propelled through the dining room and R88 stated she did not know what she was going to do today. On 6/4/25 at 12:58 p.m., during a follow up interview TR-D confirmed R88 was not consistently offered or included in activities and was unsure if other staff had included R88 in activities. TR-D confirmed that she was responsible for the TCU residents' activity planning and should have ensured offers were made based on R88's assessment. On 6/4/25 at 2:57 p.m., the administrator stated residents were expected to be offered activities based of interests and specific to each resident and confirmed activities staff were expected to offer and document on R88's activities. The administrator confirmed that activity offerings were expected based on the preferences and activity assessment.	21435			

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21435	Continued From page 23 R143s admission MDS dated 9/16/24, identified activity preferences were books, pets, news, engaged in favorite activities, attended religious activities and going outdoors. R143's quarterly MDS dated 4/16/25, identified cognitive impairment, diagnoses of Parkinson's disease, dementia with progressive neurological conditions. R143 had clear speech, wore hearing aids, had no impairment to vision, had the ability to understand others, used a walker/wheelchair and was dependent on staff for mobility/transfers. R143's care plan initiated 4/10/25, identified a care area of activities and had interventions to attend group activities and wanted encouragement to attend group programs for short periods and if unable to stay would be assisted out of the group. R143 would like his activity level monitored and assessed for changes, preferred to pursue independent activities such as having someone read devotions, bring pets to visit, walking, listening to music. The care plan identified R143 would notify activities if he needed independent leisure supplies and for staff to anticipate independent needs and to be reminded and assisted to group activities of interest. R143's paper chart that included an activities tab was reviewed but had no activities recorded. R143's electronic medical record (EMR) was reviewed but had no attendance to activities recorded. An activities assessment dated 10/25/24, identified R143's family was very involved and visited daily. He had attended some music events and was willing to stay for concerts if	21435			

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21435	Continued From page 24 family attended. He enjoyed going for walks around the facility and activities of interest were animals, table games, music, singing, concerts, special events, news, devotions and worship services. R143 was a gardener and had an interest in nature groups. R143's quarterly therapeutic recreation note dated 1/16/25 and 4/28/25, were reviewed and contained the same note, R143 continued to pursue independent leisure interests daily with assistance setting up as needed and participated or observed group programs as desired/able. R143's family was very involved and often visited daily. Family typically walked R143 around the neighborhood halls on 3rd floor and would at times encourage him to join activities. He had attended some music events- not a fan of polka music but more willing to stay for concerts if family attended with him. R143 used a walker for mobility and required staff/family assistance/supervision. Activities of interest include animals (had dogs), table games (risk, monopoly), music/singing/concerts (Elvis, 50's), special events, keeping up with the news, devotions and worship services (Lutheran). R143 was previously a gardener and has observed flower arrangements/nature groups when walking through the activity room with family. Independent leisure interests consist of watching tv/movies (CNN news, Netflix), visited with family, devotions, music, walking, pets, resting in my room or neighborhood lounge, and snacking as able. He often rests in the neighborhood lounge with peers where they watch tv together/ observe those passing in hallway. R143 responded to conversation and hears with loud tone and used hearing aids. His care plan has been reviewed and remained appropriate.	21435			

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21435	Continued From page 25 During an interview on 6/2/25 at 12:30 p.m., family member (FM)-A stated a calendar of activities was posted in R143's room every month, but the facility doesn't invite him to attend. Most of the activities are over by the time family arrives and felt if family doesn't take him to an activity or to church, R143 sat in his room and FM-A would appreciate if staff would invite him to activities. FM-A stated the few staff that came which was a long time ago, they would ask, but if he didn't respond or shook his head no, they would just leave. FM-A stated the facility had a shortage of staff and felt she needed to visit every day to take R143 out of his room. During an observation on 6/3/25 at 9:43 a.m., R143 was in the lounge area, laying in the recliner watching the news. During an observation and interview on 6/3/25 at 3:52 p.m., R143 was in the lounge area in a recliner. A privately paid companion (FM)-B stated I arrived today at 1:00 p.m., have been with R143 since he lived at home and came every Tuesday since R143 moved to the facility. FM-B stated no one from activities came today to invite R143 but the facility used to invite him to activities when he first came and confirmed no one has invited R143 to activities recently. Activity calendar for 6/3/25 read at 10:15 a.m. included devotions, 11:00 a.m. MacPhail music class, 2:00 p.m., bingo, 6:45 p.m. cloudberry choir concert. During an interview on 6/4/25 at 11:45 p.m., activities personnel (A)A stated R143 preferred to watch tv in the lounge with a small group, doesn't like large groups and therefore would not be invited to an activity such as bingo. A-A was aware R143 preferred music events but was unable to sit for long periods, so if staff brought	21435			

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21435	Continued From page 26 him to an activity, he would come last. A-A acknowledged R143's wife brought him to most activities but stayed to the side. The facility didn't invite R143 as much as they should, confirmed he did not attend the music event yesterday, and that he has not attended any activity by invitation recently. All activities have been with his family the past several months. During an interview on 6/4/25 at 1:18 p.m., TR-D stated the facility offered individualized activities such as an art and roving library cart, puzzles, cross words and for residents that are unable to attend large group activities we ask the nursing assistants to turn on the lounge television to view the scheduled program in a smaller group setting. Residents that need more one on one interaction could request a special friend visit or have a book read by volunteer services. Activities are tracked using point click care (computer software), but residents that decline activities were not tracked. The TR-D reviewed all R143's 2025 activity tasks reports in his EMR and confirmed no activities had been recorded. Facility Therapeutic Recreation Assessments and Documentation policy dated 5/17, indicated: Policy: To provide for official, comprehensive written records of all Resident's interests and involvement in Therapeutic Recreation programs. The Therapeutic Recreation staff are assigned the residents to which they must complete all documentation with in specified time frames. 1. Admission Assessment a. Upon admission sections Band F of the MDS will be completed and serve as the initial assessment for the resident/patient. b. A progress note which includes details of the assessment will be done c. Any corresponding raps will be completed for	21435			

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21435	Continued From page 27 appropriate sections 2. Resident Care Plans a. The care plan is developed from information that is collected in the initial assessment, observations from the resident and information obtained from their representative. b. A care plan will be developed for each resident/patient within 21 days c. Care Plan will be reviewed and updated as needed every 90 days, if a significant change occurs and as needed. 3. Daily Attendance Records a. Daily attendance will be recorded in POC b. Review records every 90 days, if a significant change occurs and as needed to ensure any emerging needs for resident / patient reassessments or care plan reviews. c. File attendance records for a minimum of 5 years d. Make use of attendance records as data for summary within resident /patient progress notes 4. Quarterly/Annual/ Significant Change Progress Notes a. Summarize information from activities, care plan and MDS assessments to complete quarterly progress note. b. Do a Therapeutic Recreation Progress note. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, activities director or designee, could engage the interdisciplinary team (IDT) to ensure residents in the facility were provided meaningful activities to meet their interests and include activities on evenings and weekends. Activities selected should be resident-centered. The administrator or designee could seek advice from resident council on likes and dislikes of types and kinds of activities offered in the facility. Activities should incorporate the resident's interests, hobbies and	21435			

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21435	Continued From page 28 cultural preferences, integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence and promote self-esteem, pleasure, comfort, education, creativity, success, and independence. ADL-related activities, such as manicures or pedicures, hair styling, and makeovers, may be considered part of the activities program. Activities selected should be individualized and customized based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts. Activities should not be confined to a department, but rather may involve all staff interacting with residents. Activities could be non-structured. The administrator or designee could ensure any activities supplied to residents in this manner be care-planned and documented in the residents ' medical record and audited. The results of those audits could be taken to quality assurance performance improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435			
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was	21545			7/18/25

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21545	Continued From page 29 prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free of significant medication errors for 1 of 6	21545	Corrected		

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21545	Continued From page 30 residents (R115) reviewed for medication administration. Findings include: R115's face sheet printed 6/5/25, indicated diagnoses of reduced mobility, cardiac pacemaker, personal history of sudden cardiac arrest, Alzheimer's disease, and heart failure. R115's quarterly Minimum Data Set (MDS) assessment dated 5/7/25, indicated moderately impaired cognition, use of wheelchair, substantial/maximal assistance with personal hygiene, lower body dressing, and bathing. R115's care plan printed revised 8/14/24, indicated self-care deficit related to congestive heart failure, pacemaker in left chest, and dementia. Staff crush my pills, mix together in applesauce to aide in swallowing. R115's physician's orders printed 6/5/25, indicated an order for metoprolol succinate extended release 50mg tablet (blood pressure medication) daily for high blood pressure. An additional order stated medications may be crushed or given in liquid form unless contraindicated or otherwise. During observation on 6/4/25 at 8:30 a.m., trained medication aide (TMA)-C prepared medications for administration to R115. TMA-C crushed acetaminophen 1000mg, metoprolol 50mg extended release, potassium 20meq, torsemide 30mg, and sertraline 100mg for ease of swallowing for R115. During interview on 6/4/25 at 8:35 a.m., prior to administration of medication to R115, TMA-C	21545			

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21545	Continued From page 31 verified she had been crushing R115's metoprolol succinate extended-release tablet for quite some time due to R115's difficulty swallowing multiple pills and intended to administer metoprolol succinate tablet crushed. TMA-C further stated R115 had an order to crush medications so she assumed metoprolol succinate extended release could be crushed. TMA-C stated she did not see the green sticker on the metoprolol succinate extended-release medication card that read: do not crush or chew. During interview on 6/4/25 at 8:45 a.m., registered nurse (RN)-E stated R115 had an order to crush medications. RN-E further stated she was unsure if the metoprolol succinate extended-release could be crushed and she would need to call the provider to check. RN-E stated she did not know the metoprolol succinate extended-release medication card included a sticker indicating not to crush or chew the medication. During interview on 6/4/25 at 9:15 a.m., RN-E stated she had called nurse practitioner (NP)-D and NP-D stated the metoprolol succinate extended-release could not be crushed. NP-D changed the order to metoprolol tartrate 25mg tablet two times per day. During interview on 6/5/25 at 8:39 a.m. director of nursing (DON) stated he had heard about this medication error yesterday and had informed RN-E that extended-release medications could not be crushed unless specifically ordered by a provider due to them needing to be released in the body over time. DON further stated it was the facility's responsibility to make sure the provider was notified if a medication needed to be changed to a different form to be crushed and he	21545			

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21545	Continued From page 32 would expect the nurses to do that. R115's blood pressure readings were reviewed for one month and ranged from 117/75 to 157/86. A facility policy on crushing of medications was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of time to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits could be taken to the quality assurance performance improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced	21565			7/18/25

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21565	Continued From page 33 by: Based on observation, interview and document review, the facility failed to ensure a self-administration of medication (SAM) assessment was completed and a provider order obtained to self-administer medications for 1 of 3 residents (R13) reviewed for medication administration. Findings include: R13's quarterly Minimum Data Set (MDS) assessment dated 4/14/25, indicated severely impaired cognition and diagnoses of Alzheimer's disease (a progressive neurological disorder affecting a person's memory, thinking, and behavior), heart failure and anxiety. The MDS indicated R13 required partial to moderate assistance for oral hygiene and substantial to maximum assistance for personal hygiene cares. R13's self-administration of medication assessment dated 11/20/23 indicated R13 did not wish to self-administer her medications. R13's undated order summary report included the following orders: - "Resident is not capable of safely self-administering medications", dated 10/31/23. - "Albuterol Sulfate Inhalation Nebulization Solution (Albuterol Sulfate) 3 milliliters (mL) inhale orally via nebulizer three times a day for cough or difficulty breathing", dated 3/13/25. R13's care plan was reviewed on 6/2/25, and revealed a lack of documentation of an assessment or provider's order she was okay to self-administer medications.	21565	Corrected		

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21565	Continued From page 34 During a continuous observation on 6/2/25 starting at 1:23 p.m., a buzzing noise was heard from outside R13's room. At 1:24 p.m., trained medication aide (TMA)-A walked out of R13's room and back to a medication cart, leaving R13's door open. Inside R13's room, a nebulizer treatment machine was observed to be running and causing the buzzing noise heard. There was tubing going from the nebulizer treatment machine to a mask that covered R13's nose and mouth, and connected below the mask was a medicine cup with liquid condensation inside. R13 sat in her wheelchair inside her room facing the nebulizer treatment machine that was plugged into the wall. TMA-A was observed going from the medication cart into other resident rooms and back to the medication cart during this time. At 1:32 p.m., TMA-A returned R13's room and announced, "time is up." R13 had removed the mask from her face and was holding it in her lap. R13 stated to TMA-A, "I don't want it on. I have had worse colds than this." TMA-A responded, "you took it off," and told R13 would need to update the doctor if she did not want the treatment any longer. TMA-A offered a drink of water and attempted to complete the medication pass, however R13 began to cry, spit out her medications and stated she wanted to leave. During interview on 6/2/25 at 1:37 p.m., TMA-A stated R13 had been "having a cough" and was taking a scheduled nebulizer treatment before breakfast and after lunch for the cough. TMA-A stated R13 did not like the afternoon nebulizer treatment but took the morning treatment "well". TMA-A confirmed she administered the nebulizer treatment and left R13 in her room unsupervised while she finished her treatment. TMA-A stated she normally kept the mask on but today was not	21565			

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21565	Continued From page 35 normal for her. TMA-A stated R13 should have an order in her medication administration record (MAR) stating it was okay for her to be left alone (or unsupervised) to finish her nebulizer treatment. TMA-A was unsure about the self-administration assessment but indicated the nursing manager would know. TMA-A expected there to be an order in place indicating R13 could complete her nebulizer treatment on her own. TMA-A reviewed MAR and identified for R13; Albuterol Sulfate Inhalation Nebulization order and opened the administration instructions and stated, "it doesn't have all the details in there." TMA-A was unable to locate a provider order indicating R13 was okay to self-administer her nebulizer treatment, however stated the MAR banner or administration instructions was where it should be. During interview on 6/2/25 at 1:47 p.m. with registered nurse (RN)-A, indicated a resident who wished to self-administer medications, including complete their nebulizer treatment after set-up unsupervised, would need a provider's order and an assessment. RN-A reviewed R13's orders and identified an order dated 10/31/23, that indicated R13 was not able to self-administer medications. RN-A confirmed this order would include nebulizer treatments. RN-A reviewed R13's electronic health record (EHR), including her MAR, and confirmed staff should stay with R13 for the duration of the nebulizer treatment to ensure she kept the mask on. RN-A explained if a resident wished to self-administer medications, staff were expected to obtain an order and perform an assessment to determine if they could safely do so. During interview on 6/5/25 at 8:45 a.m. with RN-B, indicated if a resident had an order to	21565			

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21565	Continued From page 36 self-administer their medications, it should be in the MAR and/or in the administration instructions for staff to see. During interview on 6/5/25 at 9:56 a.m., the director of nursing (DON) expected staff to follow the facility's self-administration policy and procedure. Facility Self-Administration of Medications policy revised 5/22, indicated the facility would allow residents to self-administer medications and/or treatments if the resident wished "AND" if the resident was assessed to be capable of safely self-administering medications. The policy directed staff to complete a self-administration of medication assessment and if the resident wished to self-administer and was determined to be safe to do so, to obtain a physician's order to self-administer. Further, the policy guided staff on the specificity of the self-administration order, including any modifications (if any) determined during the assessment. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self-administration of medications or treatments. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of administering their own medications or treatments initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medications or treatments. The DON or designee could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take	21565			

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21565	Continued From page 37 that information to quality assurance performance improvement (QAPI) to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21565			