DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDIC	CAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	1	ID: 62WW
	PART I -	TO BE COMPI	LETED BY T	'HE STA'	TE SURVEY AGENCY		Facility ID: 00501
 MEDICARE/MEDICAID PROVID (L1) 245347 STATE VENDOR OR MEDICAID 		3. NAME AND AL (L3) LYNGBLON (L4) 1415 ALMO	ASTEN CARE		ł	 TYPE OF ACTIC Initial Termination 	DN: <u>7 (</u> L8) 2. Recertification 4. CHOW
(L2) 009342400		(L5) SAINT PAU	L, MN		(L6) 55108	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other r Complaint
6. DATE OF SURVEY 11/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	03/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDI	NG DATE: (L35)
 11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	237 (L18) 237 (L17)	Complianc			And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	6. Scope of Se 7. Medical Dir	rvices Limit rector m Size
15. Total Contriba Boas	237 (==*)	Requireme	ents and/or Appli	ed Waivers:	* Code: A *	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 237	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Gayle Lantto, Supervisor		1	1/04/2014	(L19)	Anne Kleppe, Enforce	ment Specialist	11/06/2014_(L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	L OFFICE OR SINGLE S	TATE AGENCY	(==*)
 DETERMINATION OF ELIGIBI <u>X</u> 1. Facility is Eligible to <u>2</u>. Facility is not Eligible 	Participate		IPLIANCE WITH ITS ACT:	I CIVIL	 Statement of Fina Ownership/Contro Both of the Above 	ol Interest Disclosure Stmt	
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEM	IENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 09/01/1986	BEGINNINC	DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure	05-Fail to	<u>NTARY</u> Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI				03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	er Status Change
(L27)	•	n of Admissions: Ispension Date:	(L44)			00-Active	er Status Change
		1	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)	10/27/2014		(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245347

Electronically Delivered: November 6, 2014

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

Dear Mr. Heinecke:

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

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

Effective October 21, 2014 the above facility is certified for:

237 - Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Are Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: anne.kleppe@state.mn.us Telephone: (651) 201-4124 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 4, 2014

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

RE: Project Number S5347027 and Complaint Numbers H5347074 and H5347075

Dear Mr. Heinecke:

On September 25, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 11, 2014 that included an investigation of complaint numbers H5347074 and H5347075. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On November 3, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 11, 2014 and an investigation of complaint numbers H5347074, found to be substantiated, and H5347075, found to be unsubstantiated. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 11, 2014, effective October 21, 2014 and therefore remedies outlined in our letter to you dated September 25, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Are Klagge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: anne.kleppe@state.mn.us Telephone: (651) 201-4124 Fax: (651) 215-9697

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245347	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/3/2014
Name	e of Facility		Street Address, City, State, Zip Code	
LYNGBLOMSTEN CARE CENTER			1415 ALMOND AVENUE SAINT PAUL, MN 55108	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) I	Date	(Y4)	ltem		(Y5)	Date
ID Prefix Reg. #	F0225 483.13(c)(1)(ii)-(ii	Correction Completed 10/21/2014 i), (c)(2) -	ID Prefix Reg. #	F0226	Co	orrection ompleted //21/2014		ID Prefix Reg. #	F0246 483.15(e)(1)		Correction Completed 10/21/2014
											_
ID Prefix Reg. #		Correction Completed 10/21/2014	ID Prefix Reg. #		Co Co	orrection ompleted //21/2014		ID Prefix Reg. #		, (e)	Correction Completed 10/21/2014
ID Prefix Reg. # LSC			Reg. #		Co	orrection ompleted		Reg. #			Correction Completed
Reg. #					Co	orrection ompleted		D //			Correction Completed
Reg. #			Reg. #		Co	prrection pmpleted					
Reviewed B State Agen Reviewed B CMS RO	cy Gl	riewed By C/AK riewed By	Date: 11/04/20 Date:	Signature 14 Signature		-	15	507		Date: 11/0 Date:	3/2014
Followup to Survey Completed on: 9/11/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?						YES	NO		

DEPARTMENT OF HEALT	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDIC	CAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL	1	ID: 62WW
	PART I -	TO BE COMPI	LETED BY T	THE STAT	FE SURVEY AGENCY		Facility ID: 00501
1. MEDICARE/MEDICAID PROVIE (L1) 245347		3. NAME AND AL (L3) LYNGBLON	ASTEN CARE		ł	4. TYPE OF ACTIC	DN: <u>2</u> (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID (L2) 009342400	NO.	(L4) 1415 ALMO (L5) SAINT PAU			(L6) 55108	 Termination Validation On-Site Visit 	 CHOW Complaint Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	11/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDE	NG DATE: (L35)
2 AOA 3 Other							
11LTC PERIOD OF CERTIFICATIO	DN	10.THE FACILITY		AS:		י מי ווידו וויד	
From (a):		A. In Complia Program R	nce With equirements		And/Or Approved Waivers Of 2. Technical Personnel		
To (b):			e Based On:			7. Medical Dir	
12.Total Facility Beds	237 (L18)	1. A	cceptable POC		 4. 7-Day RN (Rural SN 5. Life Safety Code 	NF)8. Patient Room 9. Beds/Room	
13.Total Certified Beds	237 (L17)	X B. Not in Con Requirement	pliance with Prog ents and/or Appli			(L12)	
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Lisa Hakanson, HPR-Di	etary Specialist	1	0/21/2014	(L19)	Anne Kleppe, Enforcer	ment Specialist	10/23/2014 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	GIONAI	L OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBI	Participate		IPLIANCE WITH ITS ACT:	H CIVIL	 Statement of Fina Ownership/Control Both of the Above 	ol Interest Disclosure Stmt	
2. Facility is not Eligible	le (L21)						
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	I. LTC AGREEN	1ENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	ГЕ	VOLUNTARY 00	INVOLUN	NTARY
09/01/1986					01-Merger, Closure		Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburst 03-Risk of Involuntary Termination		Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	OTHER	- Status Channes
	A. Suspension	of Admissions:	(L44)		of other reason for whitehaver	07-Provid 00-Active	er Status Change
(L27)	B. Rescind Su	spension Date:	(L44)			00110010	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 25, 2014

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

RE: Project Number S5347027 and Complaint Numbers H5347074 and H5347075

Dear Mr. Heinecke:

On September 11, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the September 11, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5347074 and H5347075. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the September 11, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5347074, found to be substantiated, and H5347075, found to be unsubstantiated.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not

attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Email: gayle.lantto@state.mn.us Telephone: (651) 201-3794 Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 21, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
 - Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable. Lyngblomsten Care Center September 25, 2014 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 11, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

Lyngblomsten Care Center September 25, 2014 Page 5

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 11, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division

Email: pat.sheehan@state.mn.us Telephone: (651) 201-7205 Fax: (651) 215-0525 Lyngblomsten Care Center September 25, 2014 Page 6

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Are Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Email: anne.kleppe@state.mn.us Telephone: (651) 201-4124 Fax: (651) 215-9697

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u> DMB NO</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	CON	E SURVEY MPLETED
		245347	B. WING _			C / 11/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		11/2014
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE		
				SAINT PAUL, MN 55108		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 00	00		
F 225 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electrom be used as verificat Upon receipt of an on-site revisit of your validate that substate regulations has beet your verification sur complaint investigat the time of the stan H5347074 was found deficiencies issued was found to be un 483.13(c)(1)(ii)-(iii), INVESTIGATE/REFT ALLEGATIONS/INTE The facility must not been found guilty of mistreating residen had a finding entered registry concerning of residents or misate and report any know court of law against indicate unfitness for	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with vey was conducted and tions were also completed at dard survey. nd to be substantiated with at F225 and F226. H5347075 substantiated. (c)(2) - (4) PORT DIVIDUALS of employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a t an employee, which would or service as a nurse aide or o the State nurse aide registry	F 22	25		10/21/14
LABORATORY		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically Signed					10/03/2014

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.

PRINTED: 10/23/2014

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION IG	COM	E SURVEY IPLETED
		245347	B. WING _			C 11/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 225	involving mistreatm including injuries of misappropriation of immediately to the to other officials in a through established State survey and co The facility must haviolations are thoro prevent further pote investigation is in p The results of all in to the administrator representative and with State law (inclu- certification agency incident, and if the	isure that all alleged violations isure that all alleged violations in the neglect, or abuse, is unknown source and is resident property are reported administrator of the facility and accordance with State law disprocedures (including to the ertification agency). Inve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 22	25		
	by: Based on interview facility failed to imm abuse to the admin as required and in a and to thoroughly in residents (R21, R12 treatment by staff. Findings include: R21's Vulnerable A dated 6/30/14, reve	NT is not met as evidenced y and document review, the nediately report allegations of istrator and State agency (SA) accordance with facility policy, nvestigate allegations for 2 of 4 83) who alleged rough dult (VA) Investigation Report ealed that at 3:30 p.m. the pregistered nurse (RN)-A that		F225 It is the policy of Lyngblomsten C Center that the facility not emploi individuals who have been found abusing, neglecting, or mistreatin residents by a court of law; or ha finding entered into the State nur registry concerning abuse, negle mistreatment of residents or misappropriation of their property report any knowledge it has of ac a court of law against an employ would indicate unfitness for servi	y guilty of ng ve had a rse aide ct, y; and ctions by ee, which	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:62WW	11	Facility ID: 00501 If contir	uation shee	t Page 2 of 20

Facility ID: 00501

If continuation sheet Page 2 of 20

PRINTED: 10/23/2014

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
	DI CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	G		
		245347	B WING		(
		240347			•	11/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	JDE	
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 225	Continued From pa	200	F 22	F		
1 220		•	Г 22		off to the	
		(NA) grabbed her leg and the ressed fingers into her leg,		nurse aide or other facility st State nurse aide registry or l		
		reportedly told the NA it hurt,		authorities. The facility ensu		
		hard. In addition, R21 said		violations involving mistreath		
		ed care in a rough manner,		or abuse, including injuries of		
	"ripping her stockin	igs off" and "dropping" her		source and misappropriation		
		espectful. R21 alleged the		property are reported immed		
		rred over several week's time,		administrator of the facility a		
		to recall exact dates or times,		officials in accordance with S		
		mples of disrespect. It was		through established procedu		
		R21 had diagnoses including		facility provides evidence the		
	bipolar, partic, and	personality disorders.		violations are thoroughly inve must prevent further potentia		
	Documentation rev	ealed an internal investigation		the investigation is in progres		
		director of nursing (DON) on		facility provides that the resu		
		A had been removed from the		investigations must be repor		
	schedule. However	r, there was no documentation		administrator or his designat		
		ne SA and administrator were		representative and to other o		
		d of the allegation. The facility		accordance with State law w		
	provided a docume			working days of the incident,		
		ve Report Submission		alleged violation is verified a		
		indicated the incident was not		corrective action has been ta		
	7/1/14.	A until the following day on		assure continued compliance following plan has been impl		
	771717.			Regarding cited residents:	cificilited.	
	On 9/11/14, at 12:3	0 p.m. the DON explained the		With respect to resident R21	. the	
		is to notify the administrator of		complaint of 6-30-14 was rep		
		ail. Documentation of email		investigation was reviewed a		
		ovided that revealed a		determined appropriate action		
	notification date an	d time of 7/1/14, at 1:46 p.m.		taken. Resident R21 care pl		
		interview er 0/44/44		updated to include the malac		
		interview on 9/11/14, at 12:48		of her cognitive distortions a		
		interviewed regarding rough 14, at 3:30 p.m. RN-A did not		vulnerability assessment was R21 has been seen by her P		
		hen the administrator was		Nurse Practitioner and her m		
		d've told him on the 1st." RN-A		have been adjusted. Regard		
		also been made to the		resident has discharged. Th		
		. RN-A did not know how to		investigation was reviewed for		
		port to the SA at the time of the		notification steps.		

Facility ID: 00501

If continuation sheet Page 3 of 20

	-	I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM A	10/23/2014 APPROVEE 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	SURVEY
		245347	B. WING			C 09/1	; 1/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER			415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	process. The DON verified r the SA had been in allegation on 6/30/' to determine wheth been considered "r numerous mental h reliable reporter, ar not been assigned 6/30/14. R183's occupationa progress note date allegation of tough relayed the residen abusive attendants The OTR noted the RN-B. On 9/11/14, at 12:4 recalled the incider regarding it on her dated 4/7/14, and r	age 3 nce received training on the neither the administrator, nor nmediately notified of R21's 14. The DON was investigating her the incident would have reportable," as R21 had nealth issues, was not always a nd the alleged perpetrator had to work with the resident on al therapist/registered (OTR) d 4/7/14, included an treatment by staff. The note tt's statements, "I have but's statements, "I have they are rough with me." allegation was reported to allegation was reported to by p.m. RN-B stated she nt, and made a notation computer. The note was read that R183 felt a staff ared care in a "forceful	F 2	25	Actions taken to identify other potent residents having similar occurrences A facility wide review of all alleged violations made in 2014 was comple for proper investigations and reportir processes. Measures put in place to ensure defi practice does not occur: Procedural changes have been mad the investigation and reporting proce to clarify reporting triage and timeline and investigation timelines. Reportir logs have been implemented with re procedures to assure all allegations properly reported, investigated and finalized. Staff have been re-educate reporting procedures and appropriate have been educated on the new investigation and reporting processe nursing supervisor and social service staff have been trained in online repor to the State Agency. Effective implementation of actions w monitored by: Nursing Administration will monitor fa investigation and reporting processe	s: eted ng icient le to esses ess ess ess ess ess are eed on e staff es orting will be acility	
	being assisted with "'ouch'," but the sta concern or compas not afraid of the pe continued to care for she wanted them to gently. On 9/11/14, at 3:15 interviewed. RN-B investigation had n	curred while the resident was a toileting, and she had stated, aff did not seem to have assion. R183 stated she was rson, and was okay if the staff or her, however, in the future, o deliver care more slowly and 5 p.m. the DON and RN-B were verified that a formal report or ot been completed, nor had mmediately reported to the			follow-up as indicated. Those responsible to maintain comp will be: The Director of Nursing and/or desig will audit all investigations via an inci log spreadsheet to assure all necess steps of investigating and reporting alleged violations have been comple The data collected will be presented Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly G Assurance Meeting. At that time the	gnee ident sary eted. to the Quality	

Facility ID: 00501

If continuation sheet Page 4 of 20

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
	ST CONTRECTION		A. BUILDING			
		245347	B. WING		09/	11/2014
NAME OF I	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER		415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 225 F 226 SS=D	R183's report shou according to the fac The facility's 5/29/1 Prevention Policy re who had reason to was being or had b immediately report the Administrator, I person-to-person c the report was then suspected abuse to 483.13(c) DEVELO ABUSE/NEGLECT The facility must de policies and proceo	he SA. The DON verified Id have been reported cility's policy. 3 Vulnerable Adult/Abuse evealed a mandated reporter believe a vulnerable adult (VA) een abused, "shall that information internally to DON, or designee via ontact." The person receiving directed to immediately report o the SA. P/IMPLMENT , ETC POLICIES	F 225 F 226	Quality Assurance committee will the decision/re-commendation re any necessary follow-up studies. Completion date for certification p only is October 21st, 2014.	garding	10/21/14
	This REQUIREMEI by: Based on interview facility failed to follo investigation and in administrator and S residents (R21, R12 treatment by staff. Findings include: The facility's 5/29/1 Prevention Policy re	NT is not met as evidenced v and document review, the ow facility policy regarding nmediate reporting to the State agency (SA) for 2 of 4 83) who alleged rough 3 Vulnerable Adult/Abuse evealed a mandated reporter believe a vulnerable adult (VA)		F226 It is the policy of Lyngblomsten C Center that the facility develop ar implement written policies and pr that prohibit mistreatment, negled abuse of residents and misappro of resident property. To assure c compliance the following plan has implemented. Regarding cited residents: With respect to resident R21, the complaint of 6-30-14 was reporte investigation was reviewed and	d ocedures it, and oriation ontinued s been	

Facility ID: 00501

If continuation sheet Page 5 of 20

				TIC:			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
)
		245347	B. WING			09/1	1/2014
NAME OF I	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
LYNGBL	OMSTEN CARE CEN	TER			415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 226	Continued From pa	age 5	F 2	26			
	the Administrator, E person-to-person c the report was then suspected abuse to Vulnerable Adult Gu R21's VA Investigat revealed that at 3:3 registered nurse (R (NA) grabbed her le pressed fingers into reportedly told the I hard. In addition, F care in a rough mai off" and "dropping" disrespectful. R21 occurred over seve unable to recall exa specific examples of the report R21 had panic, and persona Documentation rev was initiated by the 6/30/14, and the N/ schedule. However on the report that th immediately notified provided a docume ReportInvestigativ Completed, which i submitted to the SA 7/1/14.	tion Report dated 6/30/14, 60 p.m. the resident reported to RN)-A that a nursing assistant eg and the aide intentionally o her leg, causing pain. R21 NA it hurt, and not to press so R21 said the NA had delivered nner, "ripping her stockings her legs, and was alleged the incidents had eral week's time, but she was act dates or times, or give of disrespect. It was noted in diagnoses including bipolar, lity disorders. ealed an internal investigation of director of nursing (DON) on A had been removed from the r, there was no documentation he SA and administrator were d of the allegation. The facility ent titled Incident ve Report Submission indicated the incident was not A until the following day on			determined appropriate actions we taken. Resident R21 care plan has updated to include the maladaptive of her cognitive distortions and her vulnerability assessment was upda R21 has been seen by her Psychia Nurse Practitioner and her medicat have been adjusted. Regarding R2 resident has discharged. The inter investigation was reviewed for prop notification steps. Actions taken to identify other poter residents having similar occurrence A facility wide review of all alleged violations made in 2014 was compl for proper investigations and report processes. Measures put in place to ensure de practice does not occur: Procedural changes have been ma the investigation and reporting proc to clarify reporting triage and timelin and investigation timelines. Report logs have been implemented with r procedures to assure all allegations properly reported, investigated and finalized. Staff have been re-educa reporting procedures and appropria have been educated on the new investigation and reporting process nursing supervisor and social servi- staff have been trained in online re- to the State Agency. Effective implementation of actions monitored by: Nursing Administration will monitor	s been impact ted. tric ions 183, the nal ber ntial es: leted ing eficient de to cesses ness ting eview s are ated on ate staff ces. All ces porting will be	
	facility's system wa allegations via ema	0 p.m. the DON explained the s to notify the administrator of iil. Documentation of email ovided that revealed a			Nursing Administration will monitor investigation and reporting process follow-up as indicated. Those responsible to maintain com	es and	

Facility ID: 00501

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		PLETED
		245347	B. WING		() 1/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•	11/2014
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 226	notification date an RN-A verified in an p.m. that R21 was treatment on 6/30/ ⁷ recall for certain wh notified, "but I woul stated a report had evening supervisor make an online rep incident, but had si process. The DON verified r the SA had been in allegation on 6/30/ ⁷ to determine wheth been considered "r numerous mental h reliable reporter, ar not been assigned 6/30/14. R183's occupationa progress note date allegation of tough relayed the residen abusive attendants The OTR noted the RN-B. On 9/11/14, at 12:4 recalled the incider regarding it on her	age 6 d time of 7/1/14, at 1:46 p.m. interview on 9/11/14, at 12:48 interviewed regarding rough 14, at 3:30 p.m. RN-A did not been the administrator was d've told him on the 1st." RN-A also been made to the . RN-A did not know how to bort to the SA at the time of the nce received training on the heither the administrator, nor mediately notified of R21's 14. The DON was investigating her the incident would have eportable," as R21 had health issues, was not always a nd the alleged perpetrator had to work with the resident on al therapist/registered (OTR) d 4/7/14, included an treatment by staff. The note it's statements, "'I have . They are rough with me.'" e allegation was reported to 55 p.m. RN-B stated she ht, and made a notation computer. The note was ead that R183 felt a staff	F 22	6 will be: The Director of Nursing and will audit all investigations of log spreadsheet to assure steps of investigating and r alleged violations have bee The data collected will be p Quality Assurance committ Director of Nursing. The da reviewed/discussed at the Assurance Meeting. At that Quality Assurance committ the decision/re-commenda any necessary follow-up st Completion date for certific only is October 21st, 2014.	via an incident all necessary eporting on completed. presented to the ee by the ata will be monthly Quality time the ee will make tion regarding udies. ation purposes	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FC	ORM	10/23/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE COMF	SURVEY PLETED
		245347	B. WING			09/1	; 1/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CENT	ſER			415 ALMOND AVENUE AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 226 F 246 SS=D	concern or compas not afraid of the per continued to care for she wanted them to gently. On 9/11/14, at 3:15 interviewed. RN-B investigation had not the incident been in administrator and th R183's report shoul according to the face 483.15(e)(1) REAS OF NEEDS/PREFE A resident has the r services in the facili accommodations of preferences, excep	sion. R183 stated she was rson, and was okay if the staff or her, however, in the future, o deliver care more slowly and p.m. the DON and RN-B were verified that a formal report or of been completed, nor had nmediately reported to the ne SA. The DON verified id have been reported cility's policy. ONABLE ACCOMMODATION RENCES		226			10/21/14
	by: Based on observat review, the facility fa within reach for 1 of for accident hazard Findings include: R49 was observed approximately 30 de at 1:27 p.m. The ch	NT is not met as evidenced ion, interview, and document ailed to ensure a call light was f 3 residents (R49) reviewed s. seated in a chair reclined at egrees in his room on 9/9/14, air was facing the residents' ximately two feet away from			F246 It is the policy of Lyngblomsten Care Center that each resident has the right reside and receive services in the facil with reasonable accommodations of individual needs and preferences, exc when the health and safety of the individual or other residents would be endangered. To assure continued compliance the following plan has bee implemented.	ility cept	

Facility ID: 00501

If continuation sheet Page 8 of 20

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			`́сом	E SURVEY PLETED
	245347	B. WING		C 09/11/2014	
ROVIDER OR SUPPLIER				09/	11/2014
			1415 ALMOND AVENUE		
JMSTEN CARE CEN	IER		SAINT PAUL, MN 55108		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETIC DATE
Continued From pa	ae 8	F 24	6		
the corner of the be out of his reach, an grab bar on the bec himself to an uprigh explained that he w help him into bed. call light. As R49 ar assistance to arrive noises as if exerting a nursing assistant then left the room to 1:40 p.m. with a lice LPN-A verified R49 reach the call light t then left the room to NA-B followed, leav The resident was no continued to make from his chair. R49 see how long it take When LPN-A return he stated, "Of cours his room we expect reach. It was an aw brought [R49] to his was right behind he tried to keep R49 w not in bed. He was when on the toilet. A trained to ensure ca resident's reach. A to bed. R49 was again obs 9/10/14, at 10:45 a.	d. The resident's call light was d was wrapped around the l. R49 was attempting to pull at position in the chair, and as waiting for someone to The surveyor activated R49's ad the surveyor waited for e, R49 made groaning-type g energy to move. At 1:35 p.m. (NA)-B entered the room and o get help. NA-B returned at ensed practical nurse (LPN)-A. would not have been able to to summon assistance. LPN-A to answer a telephone call. ring R49 and the surveyor. ot given his call light, and he noises as he tried to get up 9 stated to the surveyor, "You es to get help around here?" ned to R49's room at 1:44 p.m. se when we bring a resident to a their call light to be within kward time. The housekeeper a room and she thought the NA er." LPN-A explained that they ithin their eyesight if he was capable of using the call light Also, housekeepers had been all lights were placed within a t 1:52 p.m. R49 was assisted	Γ 24	Regarding cited residents: With respect to resident R49, hi plan was reviewed and found to appropriate regarding his ability and utilize the resident call syste care plan was updated to reflect resident s ability to use the call communicate his needs verbally make his needs known to staff. Actions taken to identify other p residents having similar occurre Care plans for residents capable the resident call system have be reviewed for accuracy of interve related to call light access and u Care plans for other residents in of utilizing the resident call syste reviewed to assure they receive accommodating the needs and preferences. Staff have been re to assure all residents have acc resident call system when unatt Measures put in place to ensure practice does not occur: Resident Call System policy was developed including clarification purpose and intent of call syster assuring residents have the abil access staff regardless of ability accessibility. Staff have been re on the requirements for access resident call system for all capa residents. Staff have been re-e on how to assure other resident incapable of accessing the resident system receive services accom	be to access em. The the system, y, and otential nces: e of using en ntions utilization. ncapable em were services -educated ess to the ended. e deficient s of n and ity to y or e-educated to the ble ducated s lent call modating	
	S FOR MEDICARE OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER DMSTEN CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pathe the corner of the be out of his reach, an grab bar on the beat himself to an upright explained that he with help him into bed. call light. As R49 ar assistance to arrive noises as if exerting a nursing assistant then left the room to 1:40 p.m. with a lice LPN-A verified R49 reach the call light to then left the room to NA-B followed, leav The resident was no continued to make from his chair. R49 see how long it take When LPN-A return he stated, "Of cours his room we expect reach. It was an aw brought [R49] to his was right behind he tried to keep R49 with not in bed. He was when on the toilet. A trained to ensure ca resident's reach. A to bed.	F CORRECTION IDENTIFICATION NUMBER: 245347 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 the corner of the bed. The resident's call light was out of his reach, and was wrapped around the grab bar on the bed. R49 was attempting to pull himself to an upright position in the chair, and explained that he was waiting for someone to help him into bed. The surveyor activated R49's call light. As R49 and the surveyor waited for assistance to arrive, R49 made groaning-type noises as if exerting energy to move. At 1:35 p.m. a nursing assistant (NA)-B entered the room and then left the room to get help. NA-B returned at 1:40 p.m. with a licensed practical nurse (LPN)-A. LPN-A verified R49 would not have been able to reach the call light to summon assistance. LPN-A then left the room to answer a telephone call. NA-B followed, leaving R49 and the surveyor. The resident was not given his call light, and he continued to make noises as he tried to get up from his chair. R49 stated to the surveyor, "You see how long it takes to get help around here?" When LPN-A returned to R49's room at 1:44 p.m. he stated, "Of course when we bring a resident to his room we expect their call light to be within reach. It was an awkward time. The housekeeper brought [R49] to his room and she thought the NA was right behind her." LPN-A explained that they tried to keep R49 within their eyesight if he was not in bed. He was capable of using the call light when on the toilet. Also, housekeepers had been trained to ensure call lights were placed within a resident's reach. At 1:52 p.m. R49 was assisted <td>S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 245347 B. WING</td> <td>S FOR MEDICARE & MEDICAID SERVICES of DEFICIENCIES (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING </td> <td>STOR MEDICARE & MEDICAID SERVICES OND NO. OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DUT OP DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DUT REVIDER OR SUPPLIER 245347 B. WING (X3) DUT DESTEN CARE CENTER STREET ADDRESS, CITY, STATE, 2IP CODE 135 ALMOND AVENUE 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 A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 8 the corner of the bed. The resident's call light was out on bises as if exerting energy to move. AT 135 p.m. a nursing assistanc to arrive, R49 made groaning-type noises as if exerting energy to move. AT 135 p.m. a nursing assistanc (DA). Be netred the room and help him into bed. Thay survey or waited for assistance to arrive, R49 made groaning-type noises as if exerting energy to move. AT 135 p.m. a nursing assistant (NA)-B entered the room and help filt to summon assistance. LPN-A then left the room to gat help. NA-B followed, leaving R49 and the surveyor, "You see how long it takes to get help around here?" F 246 When LPN-A returned to R49's room at 1:44 p. the stated, "O course when we bring a resident's may not in bed. Have sapable of using the call light to summon assistance. Trade to eas an adwixed time. The housekeepers hought [R49] to his: room and she thought the NA was right behind her.". LPN-A explained that they when on the toilet. Also, housekeepers had been trained to eas any Whend tine.</td>	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI A. BUILDIN 245347 B. WING	S FOR MEDICARE & MEDICAID SERVICES of DEFICIENCIES (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING	STOR MEDICARE & MEDICAID SERVICES OND NO. OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DUT OP DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DUT REVIDER OR SUPPLIER 245347 B. WING (X3) DUT DESTEN CARE CENTER STREET ADDRESS, CITY, STATE, 2IP CODE 135 ALMOND AVENUE 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 A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 8 the corner of the bed. The resident's call light was out on bises as if exerting energy to move. AT 135 p.m. a nursing assistanc to arrive, R49 made groaning-type noises as if exerting energy to move. AT 135 p.m. a nursing assistanc (DA). Be netred the room and help him into bed. Thay survey or waited for assistance to arrive, R49 made groaning-type noises as if exerting energy to move. AT 135 p.m. a nursing assistant (NA)-B entered the room and help filt to summon assistance. LPN-A then left the room to gat help. NA-B followed, leaving R49 and the surveyor, "You see how long it takes to get help around here?" F 246 When LPN-A returned to R49's room at 1:44 p. the stated, "O course when we bring a resident's may not in bed. Have sapable of using the call light to summon assistance. Trade to eas an adwixed time. The housekeepers hought [R49] to his: room and she thought the NA was right behind her.". LPN-A explained that they when on the toilet. Also, housekeepers had been trained to eas any Whend tine.

Facility ID: 00501

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CENTE	<u>RS FOR MEDICA</u> RE	& MEDICAID SERVICES			OMB NO.	APPROVE 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	_ COMF	SURVEY PLETED	
		245347	B. WING _		— 09/ 1) 1 /2014	
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 5510	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE	
F 246	approximately five i was observed in the feet from R49. Wh she explained she call light, because s to assist the reside "coming right back." Following the obset stated he would no within a resident's r gone for a short arr lift or something like staff to put a call lig when all cares were Later that day at 2:: activating his call lig I am in pain." At the nursing (ADON) ve light to summon as R49's significant ch (MDS) dated 8/12/2 moderate cognitive understood and ab required extensive perform activities o and he was unable The care plan for R resident was incont for toileting. Staff w call light was within of his toileting need for risk for falls initia at risk for issues re	feet out of R49's reach. NA-C e hallway approximately 125 en she entered R49's room, had not ensured R49 had his she was looking for equipment int to the toilet and was " rvation at 10:46 a.m. LPN-A t expect staff to put a call light reach if "they were going to be nount of time, to get a towel or e that." LPN-A would expect the within a resident's reach e completed. 22 p.m. R49 was observed ght. He reported, "I need help. e time, the assistant director of rified R49 was able to use call sistance. hange Minimum Data Set 14, identified R49 displayed impairment, but was le to understand. The resident assistance from staff to f daily living and to transfer,	F 24	 when unattended. Effective implement monitored by: Nursing Administratives resident call system residents to access and follow-up as incomplete will be: The Director of Nurse will complete two reall audits each week for one resident call system week for two monthe compliance with factor resident access to of collected will be prefixed Assurance committed Nursing. The data were reviewed/discussed Assurance Meeting Quality Assurance of the decision/re-commany necessary follow 	is and the ability of staff for their needs dicated. to maintain compliance sing and/or designee sident call system or one month and then stem audit every other s to assure tility call system and care. The data sented to the Quality ee by the Director of will be at the monthly Quality . At that time the committee will make mendation regarding w-up studies.		

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED B NO. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED		
		245347	B. WING _		C 09/11/2014		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	OMSTEN CARE CEN	red		1415 ALMOND AVENUE			
	OWSTEN CARE CEN	IER	SAINT PAUL, MN 55108				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 246	Continued From pa	ge 10	F 24	6			
	(DON) and ADON s staff would deliver of	p.m. the director of nursing stated the expectation was that care to residents as directed in cluding placing call lights within					
F 253 SS=D	directed staff to ens "within easy reach of resident was in or of at all times. Staff w lights "as quickly as minutes for an eme minutes of a room I assignment." The p	urpose was cited as "A call ed to respond to a resident's EKEEPING &	F 25	53	10/21/14		
	maintenance servic	ovide housekeeping and ses necessary to maintain a nd comfortable interior.					
	by: Based on interview review, the facility fa were kept clean and residents (R329, R observed. Findings include: R329's carpeting w	NT is not met as evidenced v, observation and document ailed to ensure resident rooms d in good repair for 3 of 40 123, R64) whose rooms were as observed on 9/8/14, at p.m. An L-shaped heavily		F253 It is the policy of Lyngblomsten Care Center that the facility provide housekeeping and maintenance serv necessary to maintain a sanitary, ord and comfortable interior. To assure continued compliance the following p has been implemented. Regarding cited residents: With respect to resident R329, carpe	vices derly, blan		

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PRINTED: 10/23/2014

		AND HUMAN SERVICES			O		APPROVE 0938-039
TATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245347	B. WING _			09/1) 1/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	E, ZIP CODE	
LYNGBL	OMSTEN CARE CEN	TER			415 ALMOND AVENUE AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 253	stained area measu	uring approximately two feet by	F 25	53	has been shampooed twice in the p month and is now in good condition		
	six inches was noted on the carpet. When asked about the stains R329 stated, "Someone crapped on it and didn't clean it up." R123's room observed unclean on 9/9/14, at 9:08 a.m. Vents underneath the air conditioning unit as well as the bottoms of the curtains above the vent were heavily soiled. Carpeting in front of an armchair in the room was heavily soiled and				Housekeeping staff will monitor the condition moving forward. R123 s conditioning vent unit and draperies	air s were	
					cleaned thoroughly and will be mon by housekeeping staff ongoing; roo carpet was removed and replaced of -14. R64 s carpet was removed an	m on 9-30 id	
	stained in an appro	m was neavily solled and ximate two by one foot dark f the dresser and small shelf			replaced on 9-30-14; a carpet guard now installed to help prevent foods being ground into the carpet. Actions taken to identify other poter residents having similar occurrence	from ntial	
		ng was heavily soiled, matted, en observed on 9/9/14, at 9:44			audit of the resident rooms that are carpeted was completed by the Dire Housekeeping on 9-20-14. Carpets needing replacement are scheduled	ector of	
	environmental serv p.m. The ESD resp	our was requested with the ices (ESD) on 9/11/14, at 2:27 bonded, "Is one of the dirty e've had issues with [R64] not			replaced within the first quarter of 2 The thorough cleaning auditing she been reviewed and revised to more identify and communicate needed f	et has clearly	
	letting us do the wo come out of her roo take to put down ne	ork," as the resident did not om for the 4-5 hours it would ew carpeting. The ESD said really like to see the carpeting			maintenance / cleaning / shampooin their supervisor for follow up. All sta have been educated on reporting an unsanitary conditions to a resident	ng to aff ny	
	stains" The ESD informed the ESD " carpeting due to the	can see it's threadbareI see D reported nursing staff had "not right now" to replacing the e resident's anxiety when she's			environment. Measures put in place to ensure de practice does not occur: Education provided to all Housekeeping staff	will be	
	clinical manager (C	cation dated 8/11/14, from the M) to the social services			regarding methods to audit the con- of resident rooms, including but not to air conditioning units, draperies a flooring, with subsequent communit of follow up peopled by their supervision	limited and cation	
	on 9/11/14. The CI would be willing to she wanted the res	was provided to the surveyor M, asked the SSC whether she call R64's daughter to see if ident's carpet replaced. The it a message with R64's			of follow up needed by their supervi Quarterly each resident s environn will be evaluated for a sanitary, orde and comfortable interior. Effective implementation of actions	nent erly,	

Facility ID: 00501

		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245347	B WING				
	PROVIDER OR SUPPLIER	243347		STREET ADDRESS, CITY, STATE, ZIP CODE	09/	11/2014	
				1415 ALMOND AVENUE			
LYNGBL	OMSTEN CARE CEN	TER	SAINT PAUL, MN 55108				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 253	Continued From pa	age 12	F 25	3			
		ek and had not hear back from	1 20	monitored by the Director of			
		g the carpet. No additional		Housekeeping.			
	information regardi	ng the carpet was provided.		Those responsible to maintain of will be:	compliance		
		p.m. RN-C explained that		Director of Housekeeping or de			
		is of schizophrenia, and had		audit condition of 10% of reside			
		ng in her room cleaned for The room had been "cleaned		each week for 1 quarter, then 1 month thereafter, with results re			
		bout 18 months prior, when		monthly to the QA Committee to			
	R64 had been hos	pitalized. RN-C and the		proper compliance with procedu	ures. At		
		R64 at 3:22 p.m. When asked the carpeting in the room, R64		that time the QA committee will			
		nice" to have the carpeting		decision/recommendation regard necessary follow-up studies.	ung any		
		d, and said she would allow		Completion date for certification only is October 21st, 2014.	n purposes		
	•	-		· , · · · · · · · · · · · · · · · · · ·			
		p.m. R329's carpeting was me condition as on 9/8/14. A					
		RN)-E was then asked about					
	the condition of the	carpeting and said she was					
		in and it had not been reported					
	to her. RN-A adde	were in the resident's room					
	daily, and the stain	should have been reported.					
		nterview, RN-A called the					
		b)-A. Hskp-A verified the stain ted to their department for					
	cleaning.						
		ent titled Dorothea and					
		ughs was reviewed and					
	indicated each resi	dent room would get a					
		weekly, and included a					
		lay of the week it should be ge the schedule if needed, and					
		risor if it was done. The form					
	indicated a thoroug	h cleaning would include, "If					
	room has carpet, it	must be edged and					

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULT	IPLE CONSTRUCTION	(V2) DAT	0938-039 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
			-		С	
		245347	B. WING _		09/	11/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 253 F 282	vacuumed." There shampooing or rep further indicated, "L everything is prese & maintenance rep time." Another undated do Cleaning Check Lis "Cubicle curtain and hanging correctly	ge 13 was no indication of criteria for acement. This document ook at the room, see that ntable and all painting, leaks, airs are done by you at this boument titled Thorough Room at included check off blanks for d draperies are clean and Floor in room is cleaned" RVICES BY QUALIFIED	F 25			10/21/14
SS=D	PERSONS/PER C/ The services provided b					
	by: Based on observat review, the facility f were followed for 1 for accident hazard Findings include: R49's care plan init resident was incont for toileting. Staff w call light was within of his toileting need for risk for falls initia at risk for issues re	NT is not met as evidenced tion, interview, and document ailed to ensure care plans of 3 residents (R49) reviewed s. iated 8/27/14, noted the inent and dependent on staff ere directed to ensure R49's reach so he could alert staff ls. Additionally, the care plan ated 2/20/12, noted R49 was lated to safety, and staff were him to ask for assistance to		The preparation of the followin correction for these deficiencies constitute and should not be int as an admission nor an agreem facility of the truth of the facts a conclusions set forth in the stat deficiencies. The plan of correct prepared for these deficiencies executed solely because it is re provisions of State and Federal Without waiving the foregoing s the facility states that: F282 It is the policy of Lyngblomsten Center that the services provide arranged by the facility must be	a does not erpreted lent by the lleged on ement of tion was quired by law. tatement, Care ed or	

Facility ID: 00501

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		AND HUMAN SERVICES				FORM	10/23/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			X3) DATE COMF	SURVEY PLETED
		245347	B. WING	i		C 09/11/2014	
NAME OF F	PROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER			415 ALMOND AVENUE		
				Э	AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page 14 R49 was observed seated in a chair reclined at			282	by qualified persons in accordance w		
	approximately 30 d at 1:27 p.m. The ch bed and was appro- the corner of the be- out of his reach, an grab bar on the be- himself to an uprigh explained that he w help him into bed. call light. As R49 an assistance to arrive noises as if exerting a nursing assistant then left the room to 1:40 p.m. with a lice LPN-A verified R49 reach the call light then left the room to NA-B followed, leav The resident was n continued to make from his chair. R49 see how long it take When LPN-A return he stated, "Of cours his room we expect reach. It was an aw brought [R49] to his	seated in a chair reclined at egrees in his room on 9/9/14, nair was facing the residents' ximately two feet away from ed. The resident's call light was d was wrapped around the d. R49 was attempting to pull at position in the chair, and ras waiting for someone to The surveyor activated R49's and the surveyor waited for e, R49 made groaning-type g energy to move. At 1:35 p.m. (NA)-B entered the room and to get help. NA-B returned at ensed practical nurse (LPN)-A. would not have been able to to summon assistance. LPN-A to answer a telephone call. <i>v</i> ing R49 and the surveyor. ot given his call light, and he noises as he tried to get up to get help around here?" the to R49's room at 1:44 p.m. se when we bring a resident to their call light to be within dward time. The housekeeper a room and she thought the NA er." LPN-A explained that they			each resident s written plan of care. assure continued compliance the following plan has been implemented Regarding cited residents: With respect to resident R49, his car plan was reviewed and found to be appropriate regarding his ability to ac and utilize the resident call system. care plan was updated to reflect the resident s ability to communicate his needs verbally and make his needs known to staff. Actions taken to identify other potent residents having similar occurrences Care plans for residents capable of u the resident call system have been reviewed for accuracy of intervention related to call light access and utiliza Care plans for other residents incapa of utilizing the resident call system w reviewed to assure they receive serv accommodating the needs and preferences. Measures put in place to ensure defi practice does not occur: Resident Call System policy was developed including clarification of purpose and intent of call system and assuring residents have the ability to access staff regardless of ability or accessibility. Staff have been re-edu	d. re ccess The s tial s: using ns ation. able vere vices icient	
	not in bed. He was when on the toilet. trained to ensure ca	ithin their eyesight if he was capable of using the call light Also, housekeepers had been all lights were placed within a t 1:52 p.m. R49 was assisted			on the requirements for access to the resident call system for all capable residents. Staff have been re-educa on how to assure other residents incapable of accessing the resident of system receive services accommoda their needs and preferences.	ited call	

Facility ID: 00501

						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED
					(5
		245347	B. WING			1/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 282	Continued From pa	ige 15	F 282	2		
	9/10/14, at 10:45 a. the upright position away from the bed. around the grab ba approximately five to was observed in the feet from R49. Wh she explained she is call light, because as to assist the resider "coming right back." Following the obser stated he would not within a resident's r gone for a short arr lift or something like staff to put a call lig when all cares were Later that day at 2:: activating his call lig I am in pain." At th nursing (ADON) ve light to summon as	rvation at 10:46 a.m. LPN-A t expect staff to put a call light reach if "they were going to be nount of time, to get a towel or e that." LPN-A would expect the within a resident's reach e completed. 22 p.m. R49 was observed ght. He reported, "I need help. e time, the assistant director of rified R49 was able to use call sistance.		Effective implementation of actions monitored by: Nursing Administration will monitor resident call systems and the ability residents to access staff for their ne and follow-up as indicated. Those responsible to maintain com will be: The Director of Nursing and/or desi will complete two resident call syste audits each week for one month an one resident call system audit every week for two months to assure compliance with facility call system resident access to care. The data collected will be presented to the Q Assurance committee by the Direct Nursing. The data will be reviewed/discussed at the monthly Assurance Meeting. At that time the Quality Assurance committee will m the decision/re-commendation rega any necessary follow-up studies. Completion date for certification pu only is October 21st, 2014.	y of eeds pliance ignee em id then y other and uality or of Quality enake arding	
F 431 SS=E	(DON) and ADON s staff would deliver of their care plans, inc reach for R49. 483.60(b), (d), (e) D	p.m. the director of nursing stated the expectation was that care to residents as directed in cluding placing call lights within DRUG RECORDS, CUGS & BIOLOGICALS	F 43 [.]	1		10/21/14
	a licensed pharmad	nploy or obtain the services of cist who establishes a system ot and disposition of all				

Facility ID: 00501

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		AND HUMAN SERVICES				FORM	10/23/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245347	B. WING			(09/ 1	; 1/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LYNGBL	OMSTEN CARE CEN	TER			15 ALMOND AVENUE AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	accurate reconciliat records are in order controlled drugs is a reconciled. Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmer controls, and permi have access to the The facility must pro- permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, the facility fa- medications were m residents (R76, R22	sufficient detail to enable an sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the Il drugs and biologicals in nts under proper temperature t only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the inimal and a missing dose can	F 4	131	The preparation of the following pla correction for these deficiencies do constitute and should not be interpr as an admission nor an agreement facility of the truth of the facts alleg	es not reted by the	
EORM CMS 28		ne potential to affect 33	11	Fac	conclusions set forth in the stateme	ent of	Page 17 of 20

Facility ID: 00501

If continuation sheet Page 17 of 20

<u>CEN</u> TEI	<u>RS FOR ME</u> DICARE	& MEDICAID SERVICES			OMB NO.	APPROVEI 0938-039	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		245347	B. WING _			C 09/11/2014	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE	, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIOI DATE	
F 431	Johnson units who house stock medic Findings include: R76's eye medicati (for Xalatan) was s cart on the Boss ur bottles were availal opened date of 6/2 unopened with a re of the observation, (LPN)-B reported th effective for three r second bottle had r R76's physicians o staff to instill one d eyes at bedtime for 8/14 and 9/14 rever medication every e On 9/10/14, at app pharmacy consulta fact, latanoprost ey	on lanaoprost solution 0.000% tored for use in the medication bit on 9/8/14, at 1:30 p.m. Two ble on the cart, one with an 3/14, and a second was still date of 7/17/14. At the time a licensed practical nurse he eye medication was nonths after opening, and the hot been opened. rder dated 6/23/14, directed rop of latanoprost into both r glaucoma. The MARs for aled R76 had received the eye	F 4:	deficiencies. The plan prepared for these def executed solely becau provisions of State and Without waiving the for the facility states that: F431 It is the policy of Lyngb Center that the facility services of a licensed establishes a system of and disposition of all c sufficient detail to enable reconciliation; and deter records are in order ar of all controlled drugs periodically reconciled biologicals used in the in accordance with cur professional principles appropriate accessory instructions, and the et applicable. To assure compliance the followin implemented. Regarding cited reside With respect to R76, the lanaoprost eye solution	iciencies was se it is required by d Federal law. regoing statement, olomsten Care employ or obtain pharmacist who of records of receipt ontrolled drugs in ole an accurate ermines that drug nd that an account is maintained and . That all drugs and facility are labeled rently accepted and cautionary xpiration date when continued ng plan has been ents: he expired n was properly		
	revised 4/11/13, inc opened for use, it r temperature up to 2 R281's two opened suspension (antaci third floor medication approximately 1:45	edication package insert dicated once a bottle was nay be stored at room 25°C (77°F) for six weeks. I bottles of lansoprazole d) were stored for use in the on refrigerator on 9/8/14, at p.m. The expiration dates on 4/14 and 9/7/14. R281 had a		discarded and current Resident R281 s expi suspension was prope current supply obtained R258 s expired proch properly discarded and obtained. Resident R1 Maalox antacid was pr and current supply obt	ired lansoprazole rly discarded and d. Resident lorperazine was d current supply 23 s expired operly discarded		

Facility ID: 00501

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TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245347	B. WING _		(09/1	C 11/2014
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE	•	
LYNGBL	OMSTEN CARE CEN	TER				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 431	the resident had rec 8/6/14 to 8/15/14. A a registered nurse of which bottle had be administration for R On 9/10/14, at appr reported lansoprazo medication and the indicated on the lab R258's nausea med Compazine) had ex 8/26/14, but was sto cart on the 4th floor for 6/14 to 9/14 rev medication to be ac Although the reside of the medication d confirmed the medi medication should in potential use beyon reported she would sheet, and place it it back to the pharma R123's antacid Maa date of 5/28/14 (mo was stored for use medication room or time of the observa a current PRN orde but planned to put to bin in the medication	s, and the 8/14 MAR showed ceived the medication from At the time of the observation, (RN)-D said she was uncertain een used during the medication 8281. roximately 1:30 p.m. CP-C ole was a compounded expiration date was as bel. dication prochlorper (for kpired 13 days earlier on ored for use on the medication r Stanford unit. R258's MAR ealed an order for the dministered PRN (as needed). ent had not received any doses uring that time frame, RN-E ication order, and said the not have been stored for ad the expiration date. RN-E fill out a medication disposal in the return bag to be sent to	F 4:	31 the Dorothea and John and current supply obta Actions taken to identifi residents having simila Medications have been assure all are current, medications were remore of properly. Impending were noted and approprimplemented to assure compliance. Measures put in place practice does not occu Processes have been of assure periodic review and rooms for medicat disposal. Staff have be assuring medications a administration. Medications. Effective implementation for medications. Effective implementation medication administration medication cart/room week for two months to compliance with medication s disposal procedures.	ained. iy other potential in occurrences: in reviewed to expired by each and disposed g expiration dates briate interventions e ongoing to ensure deficient r: developed to of medication carts ion storage and een re-educated on are current upon ation Storage dated to reflect moval of expired on of actions will be will monitor ion policies related I follow-up as naintain compliance g and/or designee cation cart/room ne month and then om audit every o assure proper cation carts and storage and	

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245347	B. WING _		(09/1	C 11/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	observed on 9/10/1 present. A bottle of pharmacy label exp manufacturer's prim The bottle was date resident's use on 8/ after the expiration observed dates and "about half left," and An expired bottle of acetaminophen (for date of 5/14 was str 1:47 p.m. on the Jo medication cart. At RN-G verified the n should have been of medication cart, a h Magnesia (for cons date of 7/29/14. RN expiration date" and to be discarded. The facility's 4/20/1 Facility contained p policy and procedur directive for staff to medications from s facility's 8/13 Medic policy directed staff containers/vialsC	ge 19 t of the Dorthea unit was then 4, at 12:40 p.m. with RN-C house stock antacid had a biration date of 3/20/14, and a ted expiration date of 4/14. ed as opened by staff for a /25/14, but was four months date. RN-C verified the d reported the medication was d should have been discarded. Thouse stock pain medication r Tylenol) with an expiration ored for use on 9/10/14, at hnson unit front hall the time of the observation, nedication had expired and disposed of. In the back hall nouse stock bottle of Milk of tipation) had an expiration I-G stated, "It's past its d said the medication needed 4, Medication Storage in the ages from the pharmacy's re manual, and provided a immediately remove outdated tock supplies. In addition, the ration AdministrationOral to, "Date open all applicable heck the expiration date on eturn any expired medications	F 4:	 committee by the Director of Nursin The data will be reviewed/discusses monthly Quality Assurance Meeting that time the Quality Assurance convill make the decision/re-commend regarding any necessary follow-up studies. Completion date for certification put only is October 21st, 2014 	d at the g. At mmittee dation	

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PRINTED: 10/23/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES							09/19/2014	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/S		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		245347	245347		B. WING		09/16/2014	
LYNGBLOMSTEN CARE CENTER 1415 A				DRESS, CITY, STATE, ZIP CODE LMOND AVENUE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 000	 INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lyngblomsten Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Lyngblomsten Care Center is a 4-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1976, an addition was constructed to the South side that was determined to be of Type II(222) construction. Because the original building and 			K 000				
LABORATOP	the 1 addition are of construction, the fac building. The building is fully has a fire alarm sys the corridors, space monitored for autom notification. All resid single station smoke capacity of 237 bed the time of the surve	f the same type of cility was surveyed a fire sprinklered. The tem with smoke dete s open to the corridonatic fire department lent rooms are equip e detection. The faci s and had a census ey. 42 CFR, Subpart 48	s one facility ection in ors that is oped with lity has a of 221 at 3.70(a) is	JATURE	TITLE		(X6) DATE	

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.