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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 62WW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00501

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

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

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

4. TYPE OF ACTION: **7** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/03/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gayle Lantto, Supervisor 11/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/27/2014
(L33)

DETERMINATION APPROVAL

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,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245347	A. Building B. Wing	11/3/2014

Name of Facility	Street Address, City, State, Zip Code
LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **10/21/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **10/21/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **10/21/2014**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **10/21/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/21/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/21/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** GL/AK	**Date:** 11/04/2014	**Signature of Surveyor:** 15507	**Date:** 11/03/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

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 HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 62WW

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(L2) **009342400**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/11/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Hakanson, HPR-Dietary Specialist 10/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/23/2014 (L20)

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

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

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
09/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. 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

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

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	C 09/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigations were also completed at the time of the standard survey. H5347074 was found to be substantiated with deficiencies issued at F225 and F226. H5347075 was found to be unsubstantiated.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		10/21/14

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

Electronically 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	C 09/11/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of abuse to the administrator and State agency (SA) as required and in accordance with facility policy, and to thoroughly investigate allegations for 2 of 4 residents (R21, R183) who alleged rough treatment by staff. Findings include: R21's Vulnerable Adult (VA) Investigation Report dated 6/30/14, revealed that at 3:30 p.m. the resident reported to registered nurse (RN)-A that	F 225	F225 It is the policy of Lyngblomsten Care Center that the facility not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a	

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F 225	Continued From page 2 a nursing assistant (NA) grabbed her leg and the aide intentionally pressed fingers into her leg, causing pain. R21 reportedly told the NA it hurt, and not to press so hard. In addition, R21 said the NA had delivered care in a rough manner, "ripping her stockings off" and "dropping" her legs, and was disrespectful. R21 alleged the incidents had occurred over several week's time, but she was unable to recall exact dates or times, or give specific examples of disrespect. It was noted in the report R21 had diagnoses including bipolar, panic, and personality disorders. Documentation revealed an internal investigation was initiated by the director of nursing (DON) on 6/30/14, and the NA had been removed from the schedule. However, there was no documentation on the report that the SA and administrator were immediately notified of the allegation. The facility provided a document titled Incident Report--Investigative Report Submission Completed, which indicated the incident was not submitted to the SA until the following day on 7/1/14. On 9/11/14, at 12:30 p.m. the DON explained the facility's system was to notify the administrator of allegations via email. Documentation of email notification was provided that revealed a notification date and time of 7/1/14, at 1:46 p.m. RN-A verified in an interview on 9/11/14, at 12:48 p.m. that R21 was interviewed regarding rough treatment on 6/30/14, at 3:30 p.m. RN-A did not recall for certain when the administrator was notified, "but I would've told him on the 1st." RN-A stated a report had also been made to the evening supervisor. RN-A did not know how to make an online report to the SA at the time of the	F 225	nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility ensures that all violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. The facility provides evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The facility provides that the results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action has been taken. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R21, the complaint of 6-30-14 was reported. The investigation was reviewed and determined appropriate actions were taken. Resident R21 care plan has been updated to include the maladaptive impact of her cognitive distortions and her vulnerability assessment was updated. R21 has been seen by her Psychiatric Nurse Practitioner and her medications have been adjusted. Regarding R183, the resident has discharged. The internal investigation was reviewed for proper notification steps.	

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F 225	Continued From page 3 incident, but had since received training on the process. The DON verified neither the administrator, nor the SA had been immediately notified of R21's allegation on 6/30/14. The DON was investigating to determine whether the incident would have been considered "reportable," as R21 had numerous mental health issues, was not always a reliable reporter, and the alleged perpetrator had not been assigned to work with the resident on 6/30/14. R183's occupational therapist/registered (OTR) progress note dated 4/7/14, included an allegation of tough treatment by staff. The note relayed the resident's statements, "'I have abusive attendants. They are rough with me.'" The OTR noted the allegation was reported to RN-B. On 9/11/14, at 12:45 p.m. RN-B stated she recalled the incident, and made a notation regarding it on her computer. The note was dated 4/7/14, and read that R183 felt a staff member had delivered care in a "'forceful manner.'" This occurred while the resident was being assisted with toileting, and she had stated, "'ouch'," but the staff did not seem to have concern or compassion. R183 stated she was not afraid of the person, and was okay if the staff continued to care for her, however, in the future, she wanted them to deliver care more slowly and gently. On 9/11/14, at 3:15 p.m. the DON and RN-B were interviewed. RN-B verified that a formal report or investigation had not been completed, nor had the incident been immediately reported to the	F 225	Actions taken to identify other potential residents having similar occurrences: A facility wide review of all alleged violations made in 2014 was completed for proper investigations and reporting processes. Measures put in place to ensure deficient practice does not occur: Procedural changes have been made to the investigation and reporting processes to clarify reporting triage and timeliness and investigation timelines. Reporting logs have been implemented with review procedures to assure all allegations are properly reported, investigated and finalized. Staff have been re-educated on reporting procedures and appropriate staff have been educated on the new investigation and reporting processes. All nursing supervisor and social services staff have been trained in online reporting to the State Agency. Effective implementation of actions will be monitored by: Nursing Administration will monitor facility investigation and reporting processes and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will audit all investigations via an incident log spreadsheet to assure all necessary steps of investigating and reporting alleged violations have been completed. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the	

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F 225	Continued From page 4 administrator and the SA. The DON verified R183's report should have been reported according to the facility's policy. The facility's 5/29/13 Vulnerable Adult/Abuse Prevention Policy revealed a mandated reporter who had reason to believe a vulnerable adult (VA) was being or had been abused, "shall immediately report that information internally to the Administrator, DON, or designee via person-to-person contact." The person receiving the report was then directed to immediately report suspected abuse to the SA.	F 225	Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. Completion date for certification purposes only is October 21st, 2014.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow facility policy regarding investigation and immediate reporting to the administrator and State agency (SA) for 2 of 4 residents (R21, R183) who alleged rough treatment by staff. Findings include: The facility's 5/29/13 Vulnerable Adult/Abuse Prevention Policy revealed a mandated reporter who had reason to believe a vulnerable adult (VA) was being or had been abused, "shall	F 226	F226 It is the policy of Lyngblomsten Care Center that the facility develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R21, the complaint of 6-30-14 was reported. The investigation was reviewed and	10/21/14

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F 226	Continued From page 5 immediately report that information internally to the Administrator, DON, or designee via person-to-person contact." The person receiving the report was then directed to immediately report suspected abuse to the SA using the facility's Vulnerable Adult Guidance Tool. R21's VA Investigation Report dated 6/30/14, revealed that at 3:30 p.m. the resident reported to registered nurse (RN)-A that a nursing assistant (NA) grabbed her leg and the aide intentionally pressed fingers into her leg, causing pain. R21 reportedly told the NA it hurt, and not to press so hard. In addition, R21 said the NA had delivered care in a rough manner, "ripping her stockings off" and "dropping" her legs, and was disrespectful. R21 alleged the incidents had occurred over several week's time, but she was unable to recall exact dates or times, or give specific examples of disrespect. It was noted in the report R21 had diagnoses including bipolar, panic, and personality disorders. Documentation revealed an internal investigation was initiated by the director of nursing (DON) on 6/30/14, and the NA had been removed from the schedule. However, there was no documentation on the report that the SA and administrator were immediately notified of the allegation. The facility provided a document titled Incident Report--Investigative Report Submission Completed, which indicated the incident was not submitted to the SA until the following day on 7/1/14. On 9/11/14, at 12:30 p.m. the DON explained the facility's system was to notify the administrator of allegations via email. Documentation of email notification was provided that revealed a	F 226	determined appropriate actions were taken. Resident R21 care plan has been updated to include the maladaptive impact of her cognitive distortions and her vulnerability assessment was updated. R21 has been seen by her Psychiatric Nurse Practitioner and her medications have been adjusted. Regarding R183, the resident has discharged. The internal investigation was reviewed for proper notification steps. Actions taken to identify other potential residents having similar occurrences: A facility wide review of all alleged violations made in 2014 was completed for proper investigations and reporting processes. Measures put in place to ensure deficient practice does not occur: Procedural changes have been made to the investigation and reporting processes to clarify reporting triage and timeliness and investigation timelines. Reporting logs have been implemented with review procedures to assure all allegations are properly reported, investigated and finalized. Staff have been re-educated on reporting procedures and appropriate staff have been educated on the new investigation and reporting processes. All nursing supervisor and social services staff have been trained in online reporting to the State Agency. Effective implementation of actions will be monitored by: Nursing Administration will monitor facility investigation and reporting processes and follow-up as indicated. Those responsible to maintain compliance	

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F 226	Continued From page 6 notification date and time of 7/1/14, at 1:46 p.m. RN-A verified in an interview on 9/11/14, at 12:48 p.m. that R21 was interviewed regarding rough treatment on 6/30/14, at 3:30 p.m. RN-A did not recall for certain when the administrator was notified, "but I would've told him on the 1st." RN-A stated a report had also been made to the evening supervisor. RN-A did not know how to make an online report to the SA at the time of the incident, but had since received training on the process. The DON verified neither the administrator, nor the SA had been immediately notified of R21's allegation on 6/30/14. The DON was investigating to determine whether the incident would have been considered "reportable," as R21 had numerous mental health issues, was not always a reliable reporter, and the alleged perpetrator had not been assigned to work with the resident on 6/30/14. R183's occupational therapist/registered (OTR) progress note dated 4/7/14, included an allegation of tough treatment by staff. The note relayed the resident's statements, "'I have abusive attendants. They are rough with me.'" The OTR noted the allegation was reported to RN-B. On 9/11/14, at 12:45 p.m. RN-B stated she recalled the incident, and made a notation regarding it on her computer. The note was dated 4/7/14, and read that R183 felt a staff member had delivered care in a "'forceful manner.'" This occurred while the resident was being assisted with toileting, and she had stated, "'ouch'," but the staff did not seem to have	F 226	will be: The Director of Nursing and/or designee will audit all investigations via an incident log spreadsheet to assure all necessary steps of investigating and reporting alleged violations have been completed. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. Completion date for certification purposes only is October 21st, 2014.	

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F 226	Continued From page 7 concern or compassion. R183 stated she was not afraid of the person, and was okay if the staff continued to care for her, however, in the future, she wanted them to deliver care more slowly and gently. On 9/11/14, at 3:15 p.m. the DON and RN-B were interviewed. RN-B verified that a formal report or investigation had not been completed, nor had the incident been immediately reported to the administrator and the SA. The DON verified R183's report should have been reported according to the facility's policy.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was within reach for 1 of 3 residents (R49) reviewed for accident hazards. Findings include: R49 was observed seated in a chair reclined at approximately 30 degrees in his room on 9/9/14, at 1:27 p.m. The chair was facing the residents' bed and was approximately two feet away from	F 246	F246 It is the policy of Lyngblomsten Care Center that each resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health and safety of the individual or other residents would be endangered. To assure continued compliance the following plan has been implemented.	10/21/14

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F 246	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 to bed. R49 was again observed the following day on 9/10/14, at 10:45 a.m. in his room while seated in the upright position in the recliner chair, facing away from the bed. The call light was wrapped around the grab bar on the exit side of the bed,	F 246	Regarding cited residents: With respect to resident R49, his care plan was reviewed and found to be appropriate regarding his ability to access and utilize the resident call system. The care plan was updated to reflect the resident□s ability to use the call system, communicate his needs verbally, and make his needs known to staff. Actions taken to identify other potential residents having similar occurrences: Care plans for residents capable of using the resident call system have been reviewed for accuracy of interventions related to call light access and utilization. Care plans for other residents incapable of utilizing the resident call system were reviewed to assure they receive services accommodating the needs and preferences. Staff have been re-educated to assure all residents have access to the resident call system when unattended. Measures put in place to ensure deficient 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-educated on the requirements for access to the resident call system for all capable residents. Staff have been re-educated on how to assure other residents incapable of accessing the resident call system receive services accommodating their needs and preferences. Staff have been re-educated to assure all residents have access to the resident call system	

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F 246	Continued From page 9 approximately five feet out of R49's reach. NA-C was observed in the hallway approximately 125 feet from R49. When she entered R49's room, she explained she had not ensured R49 had his call light, because she was looking for equipment to assist the resident to the toilet and was "coming right back." Following the observation at 10:46 a.m. LPN-A stated he would not expect staff to put a call light within a resident's reach if "they were going to be gone for a short amount of time, to get a towel or lift or something like that." LPN-A would expect staff to put a call light within a resident's reach when all cares were completed. Later that day at 2:22 p.m. R49 was observed activating his call light. He reported, "I need help. I am in pain." At the time, the assistant director of nursing (ADON) verified R49 was able to use call light to summon assistance. R49's significant change Minimum Data Set (MDS) dated 8/12/14, identified R49 displayed moderate cognitive impairment, but was understood and able to understand. The resident required extensive assistance from staff to perform activities of daily living and to transfer, and he was unable to ambulate. The care plan for R49 initiated 8/27/14, noted the resident was incontinent and dependent on staff for toileting. Staff were directed to ensure R49's call light was within reach so he could alert staff of his toileting needs. Additionally, the care plan for risk for falls initiated 2/20/12, noted R49 was at risk for issues related to safety, and staff were directed to remind him to ask for assistance to complete tasks.	F 246	when unattended. Effective implementation of actions will be monitored by: Nursing Administration will monitor resident call systems and the ability of residents to access staff for their needs and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete two resident call system audits each week for one month and then one resident call system audit every other week for two months to assure compliance with facility call system and resident access to care. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. Completion date for certification purposes only is October 21st, 2014.	

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F 246	Continued From page 10 On 9/11/14, at 1:30 p.m. the director of nursing (DON) and ADON stated the expectation was that staff would deliver care to residents as directed in their care plans, including placing call lights within reach for R49. The 10/11 Lyngblomsten Care Center policy directed staff to ensure call lights were placed "within easy reach of the resident whether the resident was in or out of bed" and was plugged in at all times. Staff were directed to answer call lights "as quickly as possible: the standard is 5 minutes for an emergency/bathroom light and 10 minutes of a room light, regardless of assignment." The purpose was cited as "A call light signals the need to respond to a resident's request for help."	F 246		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to ensure resident rooms were kept clean and in good repair for 3 of 40 residents (R329, R123, R64) whose rooms were observed. Findings include: R329's carpeting was observed on 9/8/14, at approximately 7:00 p.m. An L-shaped heavily	F 253	F253 It is the policy of Lyngblomsten Care Center that the facility provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R329, carpeting	10/21/14

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F 253	Continued From page 11 stained area measuring approximately two feet by 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 stained in an approximate two by one foot dark area, and in front of the dresser and small shelf unit. R64's room carpeting was heavily soiled, matted, and threadbare when observed on 9/9/14, at 9:44 a.m. An environmental tour was requested with the environmental services (ESD) on 9/11/14, at 2:27 p.m. The ESD responded, "Is one of the dirty rooms [R64's]? We've had issues with [R64] not letting us do the work," as the resident did not come out of her room for the 4-5 hours it would take to put down new carpeting. The ESD said R64's family would really like to see the carpeting replaced, and "You can see it's threadbare...I see stains...." The ESD reported nursing staff had informed the ESD "'not right now'" to replacing the carpeting due to the resident's anxiety when she's out of the room. An email communication dated 8/11/14, from the clinical manager (CM) to the social services coordinator (SSC) was provided to the surveyor on 9/11/14. The CM, asked the SSC whether she would be willing to call R64's daughter to see if she wanted the resident's carpet replaced. The SSC replied she left a message with R64's	F 253	has been shampooed twice in the past month and is now in good condition. Housekeeping staff will monitor the condition moving forward. R123□s air conditioning vent unit and draperies were cleaned thoroughly and will be monitored by housekeeping staff ongoing; room carpet was removed and replaced on 9-30-14. R64□s carpet was removed and replaced on 9-30-14; a carpet guard is now installed to help prevent foods from being ground into the carpet. Actions taken to identify other potential residents having similar occurrences: An audit of the resident rooms that are carpeted was completed by the Director of Housekeeping on 9-20-14. Carpets needing replacement are scheduled to be replaced within the first quarter of 2015. The thorough cleaning auditing sheet has been reviewed and revised to more clearly identify and communicate needed floor maintenance / cleaning / shampooing to their supervisor for follow up. All staff have been educated on reporting any unsanitary conditions to a resident□s environment. Measures put in place to ensure deficient practice does not occur: Education will be provided to all Housekeeping staff regarding methods to audit the condition of resident rooms, including but not limited to air conditioning units, draperies and flooring, with subsequent communication of follow up needed by their supervisor. Quarterly each resident□s environment will be evaluated for a sanitary, orderly, and comfortable interior. Effective implementation of actions will be	

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	245347	A. BUILDING _____ B. WING _____	C 09/11/2014

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

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F 253	Continued From page 12 son-in-law last week and had not hear back from the family regarding the carpet. No additional information regarding the carpet was provided. On 9/11/14, at 3:20 p.m. RN-C explained that R64 had a diagnosis of schizophrenia, and had not had the carpeting in her room cleaned for three or four years. The room had been "cleaned and wiped down" about 18 months prior, when R64 had been hospitalized. RN-C and the surveyor spoke to R64 at 3:22 p.m. When asked about her views of the carpeting in the room, R64 stated "it would be nice" to have the carpeting cleaned or replaced, and said she would allow staff to perform the necessary work. At 9/11/14, at 3:25 p.m. R329's carpeting was observed in the same condition as on 9/8/14. A registered nurse (RN)-E was then asked about the condition of the carpeting and said she was unaware of the stain and it had not been reported to her. RN-A added that nursing and housekeeping staff were in the resident's room daily, and the stain should have been reported. At the time of the interview, RN-A called the housekeeper (hskp)-A. Hskp-A verified the stain had not been reported to their department for cleaning. An undated document titled Dorothea and Kobe-Husby Thoroughs was reviewed and indicated each resident room would get a thorough cleaning weekly, and included a schedule with the day of the week it should be done, how to change the schedule if needed, and to notify the supervisor if it was done. The form indicated a thorough cleaning would include, "If room has carpet, it must be edged and	F 253	monitored by the Director of Housekeeping. Those responsible to maintain compliance will be: Director of Housekeeping or designee will audit condition of 10% of resident rooms each week for 1 quarter, then 10% per month thereafter, with results reported monthly to the QA Committee to ensure proper compliance with procedures. At that time the QA committee will make the decision/recommendation regarding any necessary follow-up studies. Completion date for certification purposes only is October 21st, 2014.	

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F 253	Continued From page 13 vacuumed." There was no indication of criteria for shampooing or replacement. This document further indicated, "Look at the room, see that everything is presentable and all painting, leaks, & maintenance repairs are done by you at this time." Another undated document titled Thorough Room Cleaning Check List included check off blanks for "Cubicle curtain and draperies are clean and hanging correctly...Floor in room is cleaned...."	F 253		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plans were followed for 1 of 3 residents (R49) reviewed for accident hazards. Findings include: R49's care plan initiated 8/27/14, noted the resident was incontinent and dependent on staff for toileting. Staff were directed to ensure R49's call light was within reach so he could alert staff of his toileting needs. Additionally, the care plan for risk for falls initiated 2/20/12, noted R49 was at risk for issues related to safety, and staff were directed to remind him to ask for assistance to complete tasks.	F 282	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F282 It is the policy of Lyngblomsten Care Center that the services provided or arranged by the facility must be provided	10/21/14

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F 282	Continued From page 14 R49 was observed seated in a chair reclined at approximately 30 degrees in his room on 9/9/14, at 1:27 p.m. The chair was facing the residents' bed and was approximately two feet away from 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 to bed.	F 282	by qualified persons in accordance with each resident□s written plan of care. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R49, his care plan was reviewed and found to be appropriate regarding his ability to access and utilize the resident call system. The 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 potential residents having similar occurrences: Care plans for residents capable of using the resident call system have been reviewed for accuracy of interventions related to call light access and utilization. Care plans for other residents incapable of utilizing the resident call system were reviewed to assure they receive services accommodating the needs and preferences. Measures put in place to ensure deficient 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-educated on the requirements for access to the resident call system for all capable residents. Staff have been re-educated on how to assure other residents incapable of accessing the resident call system receive services accommodating their needs and preferences.	

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F 282	Continued From page 15 R49 was again observed the following day on 9/10/14, at 10:45 a.m. in his room while seated in the upright position in the recliner chair, facing away from the bed. The call light was wrapped around the grab bar on the exit side of the bed, approximately five feet out of R49's reach. NA-C was observed in the hallway approximately 125 feet from R49. When she entered R49's room, she explained she had not ensured R49 had his call light, because she was looking for equipment to assist the resident to the toilet and was "coming right back." Following the observation at 10:46 a.m. LPN-A stated he would not expect staff to put a call light within a resident's reach if "they were going to be gone for a short amount of time, to get a towel or lift or something like that." LPN-A would expect staff to put a call light within a resident's reach when all cares were completed. Later that day at 2:22 p.m. R49 was observed activating his call light. He reported, "I need help. I am in pain." At the time, the assistant director of nursing (ADON) verified R49 was able to use call light to summon assistance. On 9/11/14, at 1:30 p.m. the director of nursing (DON) and ADON stated the expectation was that staff would deliver care to residents as directed in their care plans, including placing call lights within reach for R49.	F 282	Effective implementation of actions will be monitored by: Nursing Administration will monitor resident call systems and the ability of residents to access staff for their needs and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete two resident call system audits each week for one month and then one resident call system audit every other week for two months to assure compliance with facility call system and resident access to care. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. Completion date for certification purposes only is October 21st, 2014.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		10/21/14

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F 431	Continued From page 16 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were not stored for use for 4 of 4 residents (R76, R281, R258, R123) whose medication had expired and was stored for use, as well as having the potential to affect 33	F 431	The preparation of the following plan of correction for these deficiencies does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of	

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F 431	Continued From page 17 additional residents residing on the Dorthea and Johnson units who may have received expired house stock medication. Findings include: R76's eye medication lanaoprost solution 0.000% (for Xalatan) was stored for use in the medication cart on the Boss unit on 9/8/14, at 1:30 p.m. Two bottles were available on the cart, one with an opened date of 6/23/14, and a second was unopened with a refill date of 7/17/14. At the time of the observation, a licensed practical nurse (LPN)-B reported the eye medication was effective for three months after opening, and the second bottle had not been opened. R76's physicians order dated 6/23/14, directed staff to instill one drop of latanoprost into both eyes at bedtime for glaucoma. The MARs for 8/14 and 9/14 revealed R76 had received the eye medication every evening. On 9/10/14, at approximately 1:30 p.m. the pharmacy consultant (CP)-A explained that in fact, latanoprost eye drops were only effective for 42 days after opening, if stored correctly. The latanoprost medication package insert revised 4/11/13, indicated once a bottle was opened for use, it may be stored at room temperature up to 25°C (77°F) for six weeks. R281's two opened bottles of lansoprazole suspension (antacid) were stored for use in the third floor medication refrigerator on 9/8/14, at approximately 1:45 p.m. The expiration dates on the bottles read 8/14/14 and 9/7/14. R281 had a physician's order for lansoprazole 3	F 431	deficiencies. The plan of correction prepared for these deficiencies was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F431 It is the policy of Lyngblomsten Care Center that the facility employ or obtain services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. That all drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to R76, the expired lanaoprost eye solution was properly discarded and current supply obtained. Resident R281□s expired lansoprazole suspension was properly discarded and current supply obtained. Resident R258□s expired prochlorperazine was properly discarded and current supply obtained. Resident R123□s expired Maalox antacid was properly discarded and current supply obtained. The house stock mediations: antacid, acetaminophen and Milk of Magnesia were removed from	

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F 431	Continued From page 18 milligrams/milliliters, and the 8/14 MAR showed the resident had received the medication from 8/6/14 to 8/15/14. At the time of the observation, a registered nurse (RN)-D said she was uncertain which bottle had been used during the medication administration for R281. On 9/10/14, at approximately 1:30 p.m. CP-C reported lansoprazole was a compounded medication and the expiration date was as indicated on the label. R258's nausea medication prochlorper (for Compazine) had expired 13 days earlier on 8/26/14, but was stored for use on the medication cart on the 4th floor Stanford unit. R258's MAR for 6/14 to 9/14 revealed an order for the medication to be administered PRN (as needed). Although the resident had not received any doses of the medication during that time frame, RN-E confirmed the medication order, and said the medication should not have been stored for potential use beyond the expiration date. RN-E reported she would fill out a medication disposal sheet, and place it in the return bag to be sent to back to the pharmacy. R123's antacid Maalox that had an expiration date of 5/28/14 (more than three months prior) was stored for use in the 2nd floor Dorthea Unit medication room on 9/10/14, at 12:32 p.m. At the time of the observation, RN-C verified R123 had a current PRN order for the expired medication, but planned to put the medication in the discard bin in the medication room. R123's record revealed a standing order for Maalox, and two doses had been administered on 8/30/14, and one dose on 8/31/14.	F 431	the Dorothea and Johnson neighborhoods and current supply obtained. Actions taken to identify other potential residents having similar occurrences: Medications have been reviewed to assure all are current, expired medications were removed and disposed of properly. Impending expiration dates were noted and appropriate interventions implemented to assure ongoing compliance. Measures put in place to ensure deficient practice does not occur: Processes have been developed to assure periodic review of medication carts and rooms for medication storage and disposal. Staff have been re-educated on assuring medications are current upon administration. Medication Storage policies have been updated to reflect periodic review and removal of expired medications. Effective implementation of actions will be monitored by: Nursing Administration will monitor medication administration policies related to expiration dates and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete two medication cart/room audits each week for one month and then one medication cart/room audit every week for two months to assure proper compliance with medication carts and rooms for medication storage and disposal procedures. The data collected will be presented to the Quality Assurance	

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F 431	Continued From page 19 The medication cart of the Dorthea unit was then observed on 9/10/14, at 12:40 p.m. with RN-C present. A bottle of house stock antacid had a pharmacy label expiration date of 3/20/14, and a manufacturer's printed expiration date of 4/14. The bottle was dated as opened by staff for a resident's use on 8/25/14, but was four months after the expiration date. RN-C verified the observed dates and reported the medication was "about half left," and should have been discarded. An expired bottle of house stock pain medication acetaminophen (for Tylenol) with an expiration date of 5/14 was stored for use on 9/10/14, at 1:47 p.m. on the Johnson unit front hall medication cart. At the time of the observation, RN-G verified the medication had expired and should have been disposed of. In the back hall medication cart, a house stock bottle of Milk of Magnesia (for constipation) had an expiration date of 7/29/14. RN-G stated, "It's past its expiration date" and said the medication needed to be discarded. The facility's 4/20/14, Medication Storage in the Facility contained pages from the pharmacy's policy and procedure manual, and provided a directive for staff to immediately remove outdated medications from stock supplies. In addition, the facility's 8/13 Medication Administration--Oral policy directed staff to, "Date open all applicable containers/vials...Check the expiration date on the medication. Return any expired medications to the pharmacy."	F 431	committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/re-commendation regarding any necessary follow-up studies. Completion date for certification purposes only is October 21st, 2014	

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

F5347024

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	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/16/2014**

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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 the 1 addition are of the same type of construction, the facility was surveyed as one building. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. All resident rooms are equipped with single station smoke detection. The facility has a capacity of 237 beds and had a census of 221 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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