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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7DTQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00501

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/04/2021** (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 **225** (L18)

13.Total Certified Beds **225** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	225			
(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 :
Elizabeth Silkey, Unit Supervisor 12/13/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/13/2021 (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
11/16/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2021

CMS Certification Number (CCN): 245347

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

Dear Administrator:

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 22, 2021 the above facility is certified for:

225 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 225 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 13, 2021

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

RE: CCN: 245347
Cycle Start Date: September 17, 2021

Dear Administrator:

On October 12, 2021, we notified you a remedy was imposed. On November 4, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 22, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 11, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 12, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 11, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 22, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7DTQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00501

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/17/2021** (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 **225** (L18)
13.Total Certified Beds **225** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	225			
(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 :
Kathy Hahn, HFE NE II 11/04/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 11/12/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

REVISED TO CORRECT DDPNA EFFECTIVE DATE. PLEASE DISREGARD PREVIOUS LETTER DATED 10/12/21.

Electronically delivered
November 2, 2021

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

RE: CCN: 245347
Cycle Start Date: September 17, 2021

Dear Administrator:

On September 17, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 11, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 11, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 11, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by November 11, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lyngblomsten Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 11, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 17, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing

before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
October 12, 2021

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

RE: CCN: 245347
Cycle Start Date: September 17, 2021

Dear Administrator:

On September 17, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 27, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 27, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 27, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO

only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 27, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lyngblomsten Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 27, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 17, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your

hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 09/17/2021

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
E 000	Initial Comments On 9/13/21 to 9/17/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/13//21 to 9/17//21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5347129C (MN57022), H5347130C (MN58526), H5347132C (MN64185), H5347133C, (MN65136) however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5347131C-(MN62245) H5347134C-(MN76166, MN75788, MN76195) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000		

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

Electronically Signed | 10/15/2021

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F 000	Continued From page 1 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		10/22/21

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F 550	Continued From page 2 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 4 of 4 residents (R192, R92, R190, R199) who required assistance with dining. Findings Include: During observation of the evening meal 9/13/21, on 2 North (2N) dining area: 5:00 p.m., R192 was brought to dining room and placed at a table alone. 5:20 p.m., R192 remains sitting at dining room table alone with no meal served. 5:40 p.m., R192 remains sitting at a dining room table with R6 who was served meal and eating. 5:56 p.m., nursing assistant (NA)-A brought tray and started to assist R192 to eat 56 minutes after being brought to the dining room. During an observation on 9/15/21, during the noon meal in dining room 2N: 12:28 p.m., R190, R92 and R199 were all 3 seated at a rectangular table. NA-B was sitting next to R199 assisting him to eat and stood and leaned across the table to assist R92 to take 3 bites of food. NA-B then moved and stood next	F 550	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F550 It is the policy of Lyngblomsten that each resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. To assure continued compliance the following plan has been implemented: Regarding cited residents: With respect to residents R92, R190, R199: all continue to be assisted with meals, staff have been instructed and	

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F 550	Continued From page 3 to R199 and assisted with eating. NA-B remained standing assisting all 3 residents reaching across the table to assist R92 until 12:41 p.m. when NA-C came to assist. NA-B remained standing and assisting R92 and R190. NA-C stood next to R199 and assisted him to eat. At 12:44 p.m., NA-C retrieved a chair and sat down to assist R199. NA-B continued to stand assisting R190. R92 had finished eating and picked up his plate and began licking it. During an observation on 9/16/21, during the noon meal in dining room 2N: 11:53 a.m., R192 was seated in Broda chair (chair that provides a positioning tilt and recline) in dining room with pillow tucked on her right side asleep at the dining room table alone. 12:12 p.m., R192 remains sitting in dining room at table asleep with no food present and R6 seated at the table eating. 12:30 p.m., R192 remains in dining room with no food, asleep in her chair leaning to the right side with chin almost touching her chest. 12:36 p.m., R192 remains in dining room with no food. R6 remains seated at table and has finished her meal. 12:47 p.m., R192 remains seated at the table leaning to the right with chin 1/4 inch from her chest asleep, now alone at the table. 12:55 p.m., NA-C began assisting 192 to eat. During observation and interview on 9/16/21, at 12:53 p.m. NA-C requested 192's food be heated up. NA-C stated she had to assist 2 other residents in their rooms before she could assist R192 who doesn't eat much anyway. NA-C stated "we have too many people to feed." During observation and interview on 9/16/21, at	F 550	observed to be seated when assisting the residents. Resident 192 was enrolled in hospice and deceased 10-15-21. Actions taken to identify other potential residents having similar occurrences: To assure all residents are receiving dignified meal service, administration has observed dining room meal service and noted no other residents; either being brought to the dining room and left for extended periods of time before being assisted with their meal, or staff assisting any residents in an undignified manner. Measures put in place to ensure deficient practice does not occur: All staff have been retrained on dignified meal service, including; • only bringing residents to the dining room when staff are available to assist, if assistance is needed; • serving residents promptly when arriving in the dining room; • serving all residents together so no resident is unserved while another at their table is served and eating; • serve residents in the manner they wish to be served, e.g. resident wants to sit and drink coffee and socialize with others before being served breakfast, want to be served right away, etc.; • assisting residents in a manner that is dignified and respects the individual's person e.g. not standing above, reaching across the table, etc. Facility procedure has been changed to bring residents, who are awake but not ready to be served or assisted with a meal and do not want to remain in their room, to a common space for socialization prior	

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F 550	Continued From page 4 12:58 p.m. registered nurse (RN)-A indicated NA's generally assist with feeding the residents they are responsible for throughout the shift. RN-A further indicated NA-C had 2 other residents to assist so she was just getting to assist R192 now. R192's Admission record, identified a diagnoses of vascular dementia without behavioral disturbance, cerebrovascular disease (medical conditions that affect the blood vessels of the brain and circulation) and weakness. R192's quarterly, Minimum Data Set (MDS) assessment, dated 8/18/21, identified severe cognitive impairment, and required 1 person total dependence with eating and required hospice care. R192's care plan dated 8/27/21, identified a problem with nutrition related to vascular dementia, cerebral vascular disease, arthritis of left shoulder, and weakness requiring total feeding assistance. Intervention included provide R192 with total feeding at meals. R92 R92's admission record, identified a diagnoses of Alzheimer's disease, dysphagia, nutritional deficiency, dehydration, adult failure to thrive and intracranial injury (head injury causing damage to the brain by external force). R92's admission MDS assessment dated 7/14/21, identified severe cognitive impairment, and required total assistance of one person person with eating. R92's care plan dated 7/20/21, identified a	F 550	to meal service. Neighborhood Interdisciplinary Team (IDT) will periodically review resident seating and adjust seating locations based on resident preference and need so staff can be efficiently distributed preventing a single staff having to assist more than two residents. Effective implementation of actions will be monitored by: Nursing Administration will oversee the training of staff. Nursing Administration and/or designee will audit meal service for prompt and dignified meal distribution and staff assistance, observing three meal services per week, rotating dining rooms and meal times for one month and then two meal services per week for two months. Nursing Administration can observe meal service remotely through video surveillance located in all dining rooms. Those responsible to maintain compliance will be: Nursing Administration and/or their designee will review the audit information, concerns noted during the audit process and any corrective actions taken, compiling the information before presenting to the monthly Quality Assurance Committee meetings for discussion. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions. Completion date for certification purposes only is: 10-22-21	

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F 550	Continued From page 5 problem with nutrition less than requirements with intervention including supervise at meals and provide feeding assistance. R190 R190's admission record, identified a diagnoses of dementia with behavioral disturbance, subarachnoid hemorrhage (bleeding within the brain and the tissue covering the brain), and moderate protein-calorie malnutrition. R190's annual, MDS assessment, dated 8/18/21, identified severe cognitive impairment, and required 1 person extensive assist with eating. R190's care plan dated 8/25/21, identified a problem with nutrition and has potential for inability to feed self. Goal included R190 will participate during meals as able, but will continue to allow staff to provide extensive to total feeding assistance as needed. R199 R199's admission record, included diagnoses of Parkinson's disease, Alzheimer's disease, vascular dementia, and weakness. R199's admission MDS assessment, dated 7/5/21, indicated R99 to have severe cognitive impairment, and identified R199 required extensive assist of of one person for eating. R199's care plan, reviewed on 7/12/21, identified a problem with nutrition with having potential for and inability to feed self. The goal was to allow R199 to participate during meals as able, but to continue to allow staff to provide meal setup and feeding assistance as needed.	F 550		

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F 550	Continued From page 6 During interview on 9/17/21, at 10:11 a.m. assistant director of nursing (ADON)-B indicated staff are instructed to assist a maximum of 2 people at one time. ADON-B confirmed staff are instructed to sit down while assisting and standing is not dignified dining for the resident. ADON-B further indicated staff can't have everyone sitting in the dining room at the same time and need to adjust times residents are brought to the dining room if they are not able to assist at that time. The ADON-B confirmed residents should not have to wait in the dining room for over fifty minutes to be assisted with feeding. A policy on dignified dining or resident rights was requested and none received.	F 550		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		10/22/21

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F 584	Continued From page 7 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to clean and maintain resident wheelchairs for 3 of 3 residents (R55, R83, and R138) reviewed for equipment. Findings include: R55's quarterly Minimum Data Set (MDS) assessment dated 6/16/21, indicated diagnoses of arthritis and heart failure, cognitively intact, independent with transfers, and used a walker and wheelchair for mobility R83's annual MDS assessment dated 4/7/21, indicated diagnosis of stroke and hemiplegia (paralysis of one side of the body), one-person physical assist with transfer, utilized a wheelchair	F 584	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F 584 It is the policy of Lyngblomsten that each resident has a safe, clean, comfortable and homelike environment and that the	

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F 584	Continued From page 8 for mobility and was cognitively intact. R138's quarterly MDS assessment dated 5/5/21, indicated severe cognitive impairment, diagnoses of dementia, aphasia (inability to communicate), hemiplegia ,depression, and anxiety, one-person physical assist with transfers, and used a wheelchair for mobility On 9/13/21, at 4:23 p.m. R55 was in her room seated on her bed and stated she was not happy with the cleanliness of her wheelchair. The wheelchair was observed and the left armrest was worn, vinyl torn, and padding exposed. The wheelchair seat platform had food debris on and underneath the width and length of the seat platform. The wheelchair spokes were coated with gray dust, gray debris, and lint. R55 indicated a couple years ago she complained about her wheelchair cleanliness and then the wheelchair was cleaned a couple of times and had not been cleaned since. R55 was unsure the last time her wheelchair was cleaned. During an observation on 9/15/21, at 2:17 p.m. R83's was lying in bed and her wheelchair was in her room unoccupied. The left side arm rest of the wheelchair cushion was flattened with worn material and the padding exposed. On 9/15/21, at 2:37 p.m. at R138 was in the doorway of her room, seated in her wheelchair. The wheelchair was observed with hardened food debris on seat platform, white hardened debris on and throughout the seat of the wheelchair, and the spokes coated with gray film and lint. On 9/16/21, at 12:37 p.m. R 55' s' wheelchair was observed with registered nurse (RN)-B and she	F 584	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 residents R55, R83, and R138, their wheelchairs have been thoroughly cleaned and remain cleaned to date. R55 and R83's wheelchair worn and torn armrests have been replaced. Actions taken to identify other potential residents having similar occurrences: All residents who use wheelchairs can be affected by a soiled or damaged wheelchair. All residents using wheelchairs have had their wheelchairs inspected for cleanliness and damage, all have been cleaned and those with any damage have been repaired. Measures put in place to ensure deficient practice does not occur: All nursing staff have been re-trained on the proper technique for cleaning wheelchairs and on the facility protocol for wheelchair cleaning. The facility policy for Mobility Equipment Cleaning was reviewed and updated to include schedule, frequency, and technique. The process for verifying the completion of wheelchair cleaning has been changed, requiring staff to document in Point of Care (POC), with additional questions added for staff to answer regarding the condition of the equipment (e.g. Are there any ripped, torn or cracked cushions on the wheelchair). Licensed nursing staff will oversee the successful completion of	

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F 584	Continued From page 9 verified R55's wheelchair was unclean and the left armrest was worn and the vinyl torn and needed repair. RN-B observed R83's wheelchair and verified the wheelchair needed repair to the armrest due to the worn and flattened cushion of the armrest. RN-B confirmed R138's wheelchair was unclean and needed cleaning. RN-B stated resident's wheelchairs were expected to be cleaned weekly on either Saturday or Sunday and assessed after eating for food and cleaned if visibly soiled. RN-B stated she expected staff to clean wheelchairs when visibly soiled and maintenance service requested when wheelchairs were worn or material torn. RN-B was observed to fill out a maintenance request to have R55 and R83's wheelchair arm rest replaced. On 9/16/21, at 2:55 p.m. during an interview with trained medication aide (TMA)- B she stated wheelchairs were washed and cleaned on bath days and weekends. On 9/16/21, at 2:57 p.m. during an interview with TMA-C he stated resident's wheelchairs were cleaned when visibly soiled and on the weekends. On 9/17/21, at 10:00 a.m. the director of nursing (DON) stated he expected staff to clean wheelchairs when visibly soiled and stated staff cleaned the wheelchairs routinely on the weekends. The DON stated staff were expected to assess the wheelchairs and expected torn vinyl and/or worn armrests to be replaced. The DON stated R55, R83, and R138 wheelchairs were assessed, and staff had cleaned them at the time of the interview. Policy titled Practice Guideline and Procedure:	F 584	the cleaning and inspection of wheelchairs and equipment by visually observing the process and documenting in the Clinical Treatment Administration record. Clinical Managers will periodically review POC records to confirm that all wheelchairs were cleaned per schedule. Effective implementation of actions will be monitored by: Nursing Administration will oversee the training of the staff. Nursing Administration will audit the cleanliness of 10 wheelchairs per week for one month then biweekly for two months to confirm that compliance with facility practice and policy is maintained. Any concerns noted will be documented and addressed appropriately. Those responsible to maintain compliance will be: Director of Nursing and/or their designee will review the audit information, concerns noted and corrective actions taken, compiling the information before presenting to the monthly Quality Assurance Committee meetings for discussion. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions.	

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	245347	A. BUILDING _____ B. WING _____	C 09/17/2021

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F 584	Continued From page 10 Mobility Equipment Cleaning dated 8/2019, indicated: Purpose: To provide clean and sanitary equipment for resident use. Wheelchairs, walkers, and their accessories are to be thoroughly cleaned weekly by the PM shift NAR/TMA and as needed when visibly soiled or when an odor is noted. Procedure: 1. Routinely and as needed wheelchairs, walkers, and their accessories are to be washed. 2. Routine washing will occur every weekend and the evening shift as follows a. even number rooms on Saturdays b. odd number on Sunday. 3. Routine washing schedules will be assigned as a task through point of care (POC) and staff are to document equipment washed in POC. 4. As needed equipment to be washed from visibly soiled, PRN washing should be documented in POC. 5. Washing should be done after the resident is done using it for the evening. 6. Removal pills pad Dycem etc. from the wheelchair or walker and leave in the resident's room 7. If any removable devices are soiled or odiferous, cleanse appropriately. Many items can be wiped down with a damp cloth or other cleansing white but cannot be fully immersed in water. 8. Clean the water wheelchair and/or walker in the tub/shower room using the commercial cleanser, scrub brush and water 9. Towel dry 10. Inspect the equipment. Report all repairs the maintenance staff	F 584		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		10/22/21

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F 623	Continued From page 11 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623		

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F 623	Continued From page 12 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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F 623	Continued From page 13 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written transfer notice was given to 2 of 3 residents (R29, R202) upon transfer to the hospital. In addition, the facility failed to have a system in place to ensure residents/resident representatives were given written notice upon transfer. This deficient practice had the potential to affect all 204 residents residing in the facility. Finding include: R202 was admitted to the facility on 7/8/21, with diagnosis (found on the diagnosis sheet in the medical record) that included: congestive heart failure (CHF) (heart fails to pump blood), myocardial infarction (MI) (heart attack) urinary tract infection (UTI) and dementia. Review of the discharge minimum data set (MDS) assessment dated 7/12/21, identified R202 as having memory impairment. R202 was able to	F 623	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F623 It is the policy of Lyngblomsten Care Center that before a resident is transferred or discharged, that the facility notifies the resident or the resident's representative of the transfer or discharge and the reasons for the move in writing and a language and manner they understand. The facility will also send a	

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F 623	Continued From page 14 understand and was understood. R202 required limited to extensive assistance with activities of daily living (ADL's). Review of a progress note dated 7/12/21, at 3:40 p.m. indicated R202 was transferred to the hospital at 12:35 p.m. after sustaining a fall. R202 left the facility via stretcher with paramedics at 12:35 p.m.. The progress note indicated R202 was transferred and admitted to the hospital for possible internal bleeding. The progress note indicated a bed hold packet was sent with the resident but not signed. The medical record did not include a written notice of transfer (describing the reason for transfer) when R202 was transferred and admitted to the hospital on 7/12/21. Interview with licensed social worker (LSW)-A on 9/17/21, at 9:00 a.m. confirmed a written transfer notice was not given to the resident/resident representative when transferred to the hospital on 7/12/21. LSW-A indicated it was not the facility practice to issue a written transfer notice upon transfer to the hospital or any other facility. Interview on 9/16/21, at 2:15 p.m., the director of nursing (DON) confirmed the facility did not have a policy that included a written transfer agreemen, when transferring a resident to the hospital R29's diagnosis included chronic constrictive pericarditis (thickened, lining of the heart affective hear's ability to function normally), cerebral infarction (interrupted blood supply resulting in necrotic tissue), narcissistic personality disorder, acute kidney failure, and acute respiratory failure.	F 623	copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. The reasons for the transfer or discharge will be documented in the resident record. Additionally, the facility will comply with all timing and content of said notice. Regarding cited residents: With respect to resident R29 he has returned to the facility and has transferred out and back from the hospital a second time since this citation. Regarding resident R202, resident discharge home after being sent to hospital for evaluation per the residents and resident's representatives request. Actions taken to identify other potential residents having similar occurrences: Any resident transferred or discharged out of the facility is affected by the facility transfer and discharge notification process. Measures put in place to ensure deficient practice does not occur: Facility has reviewed the Admission, Transfer, and Discharge Policy and Procedures and updated language regarding Ombudsman notification. Facility staff involved in resident transfers and discharges- namely licensed nursing staff and social workers have been trained in the new transfer and discharge requirements. Facility has created and implemented a Notice of Transfer or Discharge form based on sample language from the Minnesota Department of Health's webpage titled "Nursing Home Discharge/Transfer Notices:" Additionally, processes have been developed to	

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F 623	Continued From page 15 R29's admission Minimum Data Set dated 8/18/21, indicated R29 is understood and understands, has moderate cognition impairment and requieres total dependance of two for transfers, but is independant with electric wheelchair. R29 had been transferred to the hospital on 8/17/21, 7/24/21, 6/23/21 and 6/8/21, via ambulance transport. The medical record lacked documentation which would indicate a transfer notice had been given to the resident and/or the resident representative. During interview on 9/15/21, at 2:26 p.m. social service (SS)-A indicated the facility does not have a transfer notice document and do not give the resident or family member anything in writing upon transfer. SS-A indicated they have never had to do that prior and per the Ombudsman, just send a spread sheet with the residents name, identification and where they are transferred to monthly. During interview on 9/16/21, at 2:15 p.m., the director of nursing confirmed the facility does not have a transfer notice in writing that is given to the resident and/or resident representative. A document titled "Bed Hold and Return to the Facility Notice" did not include reason for transfer.	F 623	assure transfer/discharge notification is documented in the resident record and ombudsman notification is completed. Effective implementation of actions will be monitored by: Nursing Administration will oversee the training of staff. Social Services will audit all transfer and discharges for compliance with the provisions of F623. The Director of Social Services will correct any compliance issues immediately, adjusting processes as necessary. Those responsible to maintain compliance will be: The Director of Social Services and/or designee will review the audit information, concerns noted and corrective actions taken, compiling the information before presenting to the monthly Quality Assurance Committee meetings for discussion. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions. Completion date for certification purposes only is 10-22-21	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		10/22/21

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F 686	Continued From page 16 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions to prevent additional pressure ulcers from developing for 1 of 1 residents (R173) who had two unstageable pressure ulcers (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar). This resulted in actual harm for R173. Findings include: R173 was admitted to the facility on 8/11/21, with diagnoses (identified on the diagnosis report sheet) that included: cellulitis (bacterial skin infection), type 2 diabetes, chronic kidney disease (failure to eliminate waste products from the body), atrial fibrillation (AF) (irregular heart rate that causes poor blood flow) and heart failure (HF) (heart is unable to pump blood to the body as it should). R173's admission minimum data set (MDS) dated 8/17/21, identified R 173 as having a baseline interview for mental status (BIMS) of "15"	F 686	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F686 It is the policy of Lyngblomsten Care Center that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individuals clinical condition demonstrates that they were unavoidable; and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	

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F 686	Continued From page 17 (cognitively intact). R173 required extensive assistance with activities of daily living (ADL's) that included mobility. The MDS identified R173 as being at risk for pressure ulcers and identified 1 venous/arterial ulcer (back of left calf) with interventions of a dressing change. No other interventions were noted. The MDS did not include a diagnosis of peripheral vascular disease (a circulatory condition that reduces blood flow to the limbs). Review of the care area assessment (CAA), included PU as a care area of concern. The CAA referred to the care plan. Review of the admission (temporary) care plan dated 8/11/21, identified R173 as having physical impairment in mobility, related to being non-ambulatory. R173 was also identified as having impairment in skin integrity, secondary to cellulitis in left lower leg. Interventions included: turn and reposition every 2 hours, encourage to shift weight when in bed and wheelchair, check skin weekly on bath day, avoid massage on bony prominence's, document skin condition and report any changes to the provider, float heels, pressure reduction mattress on bed and pressure reduction cushion on chair. Review of the weekly skin checks from 8/11/21 to 9/9/21, did not identify any skin breakdown on R173's heels. R173's progress note dated 9/10/21, at 4:55 p.m. indicated R173 has a intact blister on the right heel. The blister measured 3.0 centimeters (cm) by 3.0 cm. and foot boots were placed in R173's room to wear at night. The note did not identify if this was a PU and what stage, along with description of the wound characteristics, pain, or	F 686	from developing. To assure continued compliance the following plan has been implemented: Regarding cited residents: With respect to resident R173 the resident continues to be treated for the pressure injury identified. The provider has seen and reviewed the plan of care and agrees with current interventions. The resident will continue to be followed by the Wound Care Team. Staff continue to provide treatments for off-loading of heels and provide treatments as ordered. Wound is improving, smaller in size with healthy tissue formation and no signs of infection. Actions taken to identify other potential residents having similar occurrences: All residents are at risk for the development of a new pressure injury or worsening of an existing pressure injury and have the potential to be similarly affected. Measures put in place to ensure deficient practice does not occur: The records of all residents with wounds have been audited and all necessary updates have been completed. Facility processes were reviewed and include, routine Interdisciplinary Team meetings where, the number of current Facility Acquired Pressure Injuries (FAPI's) are checked, significant changes in condition are reviewed, new or changing skin conditions are discussed and changes in resident's nutritional status (weight loss, decreased intake, difficulty swallowing, etc.) are considered. Information gathered is then utilized to develop and consider appropriate interventions to	

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F 686	Continued From page 18 treatment. There was no indication an assessment was completed to determine how the PU developed or implemented interventions to prevent additional PU from occurring. R173's progress note dated 9/14/21, at 4:53 a.m. indicated R173 had pressure injuries to both heels, 4 days after a blister was noticed on the right heel. R173's wound assessment tool dated 9/14/21, identified R173 as having a unstageable pressure ulcer to the left heel that measures 1.5 cm by 2.4 cm. The ulcer was described as having a moderate amount of serosanguineous drainage and the surrounding skin to be macerated (softening and breakdown of skin). Mepilex (a antimicrobial foam that absorbs exudate) dressing applied. The assessment identified a right heel ulcer that measured 3.5 cm by 5.0 cm, with a large amount of serosanguineous drainage. The ulcer is black/purplish in color with blistered areas. Mepilex applied. Interventions listed: offload heels in bed with pillows or heel boot. R173's nurse practitioner (NP)-A progress notes dated 9/14/21, identified R173 with bilateral edema and wounds. Right and left heel wound had been debrided in the a.m. The right heel wound was identified as having a blister last week and is now draining. Lower extremities exhibit vascular skin changes with chronic cellulitis, due to diabetes mellitus and PVD (reduced blood flow to the limbs). (PVD was not included in the admission or current diagnosis sheet) R173 has a left calf wound that measures 3.0 cm by 7.0 cm due to diabetes mellitus and poor circulation. The calf wound was present on	F 686	prevent the development, or promote healing of pressure injuries. To assure interventions are completed, staff have been trained on where treatment interventions are communicated (nursing assistant care sheets, electronic treatment record, etc.), as well as steps to take if there is evidence a treatment has been initiated but is not clearly identified on the established communication methods (e.g. heel boot in room but no direction on care sheet for its application). All nursing staff have been re-educated on the updated facility processes and the prevention and healing of pressure ulcers, including: • Routine monitoring of pressure injuries for healing; • Reassessment of a pressure injury that is not healing; • Reassessment of resident when a new pressure injury is identified; • Interventions to promote healing, prevent worsening, and development of additional pressure injuries; • And, interventions to prevent the development of pressure injuries. A new order set has been developed for licensed nursing and health information support specialist (HISS) to assure all required components of wound identification, assessment and treatment are completed when a new wound is identified. All providers have been notified of the facility expectation that any patient with a wound will be routinely assessed and documented in their progress notes. The facility Skin Care- The Prevention and Treatment of Wounds policy has	

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F 686	Continued From page 19 admission. During observation and interview on 9/14/21, at 10:00 a.m. R173 was sitting in a recliner, with legs slightly elevated on the foot rest of the recliner. Both feet were wrapped with ace bandages. R173 stated she had 2 PU's on both heels and a wound on the back of her calf. Both heels were resting directly on the foot rest of her recliner. R173 further stated she did not recall having PU's prior to admission to the facility. During observation on 9/15/21, at 2:00 p.m. R173 was observed to be sleeping in her recliner with both legs elevated. Both heels were resting on the foot rest of the recliner. No interventions were implemented to keep pressure off of the heels. During observation and interview on 9/16/21, at 10:30 a.m. R173's ulcers of the heels were measured by licensed practical nurse (LPN)-A. The right heel ulcer measured 3.8 cm by 5.2 cm., the skin was reddened around the ulcer with slough tissue in the center. The left heel ulcer measured 2.0 cm by 2.6 cm with 100 percent eschar (dead tissue). The skin was reddened and macerated (when skin is too moist) around the ulcer. LPN-A cleansed both ulcers and applied a calcium alginate dressing. R173's lower legs were slightly bluish in color. R173 stated she had cellulitis in both of her legs. LPN-A stated R173 did not have the heel ulcers upon admission, but was unsure when the heels started to break down. LPN-A further indicated R173 did not have any interventions in place, other than to wear heel protectors in bed at night. R173 stated she does not lay in her bed during the day, but rather rested in her recliner.	F 686	been revised to reflect the steps for the assessment, monitoring, notification, and treatment of a wound/injury and direction for providers documentation of wounds/injuries. Effective implementation of actions will be monitored by: Nursing Administration will monitor the facility pressure ulcer assessment, intervention implementation and monitoring and follow-up as indicated. Nursing Administration will monitor and track all facility pressure injuries weekly and audit wound documentation to assure all is thoroughly and accurately completely. Those responsible to maintain compliance will be: Director of Nursing and/or designee will review audits completed for any trends or concerns and take appropriate actions to correct. The data collected will be presented and discussed monthly at the Quality Assurance Committee meetings by the Director of Nursing. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies. Completion date for certification purposes only is: 10-22-21.	

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During observation on 9/16/21, at 12:00 p.m. R173 was sitting in her wheelchair with both heels resting on the foot pedals. R173 did not have any interventions implemented to prevent pressure on her heels. The heel protectors were laying on her bed. R173 indicated she was not sure when she was suppose to wear the heel protectors, and that the staff put them on.

During observation on 9/16/21, at 3:00 p.m. R173 was sitting in her wheel chair. Both heels were resting on the foot rest. No interventions were in place to keep pressure off of her heels while she was in her wheelchair.

During observation on 9/17/21, at 10:00 a.m. R173 was sitting in her wheelchair with both of her heels resting on the foot rest. R173's heel protectors were on the bed. Interview with registered nurse (RN)-A at this time, stated she was unsure when R173 is to wear heel protectors, but would look up the order. After RN-A looked up the order, she stated R173 was to have heel protectors on in the am and throughout the day. RN-A further indicated she was unsure who was responsible for applying R173's heel protectors.

R173's current physicians orders dated 9/16/21, included to off load /float heels every shift.

R173's nursing assistant (NA) care sheet dated 9/17/21, identifies R173 as having cellulitis in the lower extremity. The NA care sheet did not include R173's heel wounds nor did it include interventions to prevent skin breakdown .

R173's current plan of care dated 9/17/21, identified R173 as having impaired mobility and

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non-ambulatory. R173 requires assistance of 1-2 staff with positioning. R173 utilizes a wheelchair. R173 was identified as having impairment with skin integrity related to a pressure injury of the right and left heels, and a vascular wound to the left calf. Interventions included: check skin weekly and monitor, pressure redistribution mattress and chair cushion, encourage position changes and float heels.

Interview on 9/16/21, at 2:00 p.m. NA-B indicated she was not aware of R173's ulcers on the heels. NA-A indicated she follows the NA care sheet when providing care for the residents. NA-A confirmed R173's heel protectors and heel ulcers were not included on the NA care sheet.

Interview on 9/17/21, at 9:30 a.m. NA-B indicated he was not aware of R173"s heel wounds. NA-B confirmed he was assigned to provide cares for R173 that day, but was not aware of any interventions related to offloading heels.

Interview on 9/17/21, at 10:30 a.m. assistant director of nursing (ADON)-B, indicated all staff are trained on prevention of pressure ulcers. ADON-B further indicated staff should have monitored R173's pressure ulcers more closely and assure interventions were implemented to keep pressure off of the heels.

Review of the facility policy The prevention and Treatment of Wounds revised 8/19, includes the prevention and treatment of wounds. This includes a comprehensive evaluation of the risk factors and clinical condition of the resident when identified with a wound. The assessment analysis identifies and implements interventions consistent with

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F 686	Continued From page 22 residents risk factor, goals and standards of practice. Effects of the interventions are monitored and revised as the residents condition changes.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent further loss of range of motion (ROM) for 2 of 3 residents (R65, R165) reviewed for contractures and limited ROM. In addition the facility failed to ensure a physician's order was in place for physical therapy for 1 of 3 residents (R168) reviewed for range of motion. Finding include:	F 688	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states	10/22/21

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F 688	Continued From page 23 R65's facesheet printed 9/16/21, included diagnoses of hemiplegia (paralysis of one side of the body) following a CVA (cerebral vascular accident or stroke) affecting the left side of her body, and contracture (a permanent shortening of a muscle or joint) of left wrist. R65's quarterly Minimum Data Set (MDS) assessment dated 6/9/21, indicated R65 had moderate cognitive impairment, adequate hearing and vision, clear speech, was able to make herself understood and could understand others. R65 required extensive assistance of one staff for bed mobility, transfers, toileting, dressing and hygiene. R65's plan of care dated 3/19/20, indicated R65 had a self-care deficit related to CVA with left hemi [hemiplegia], and contracture of left wrist. Interventions indicated to complete upper extremity ROM with assist from nursing two times per day, 10 - 20 reps [repetitions] each. During an interview and observation on 9/14/21, at 9:24 a.m. R65's left wrist was flexed at approximately 90 degrees and the elbow was flexed at appropriately 145 degrees. R65's fingers were not clenched but were closed. R65 was able to open fingers of left hand with her right hand, and was able to extend her left wrist using her right hand, stating "...but it's tight." R65 was not able to extend her left arm at the elbow. R65 stated she no longer received occupational therapy, and no one was doing ROM exercises to her left upper extremity. R65 stated she didn't want the stiffness to get worse. During an interview on 9/14/21, at 10:06 a.m. when asked if they assisted R65 with exercises,	F 688	that: F688 It is the policy of Lyngblomsten Care Center that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless that reduction is unavoidable. That a resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent any further decreases. That a resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility unless a reduction in mobility is unavoidable. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R65, staff have been re-educated on her exercise/ROM program and any staff uncomfortable with performing the program were provided hands on demonstration. R65 has been referred to therapy to evaluate her current range of motion (ROM) to determine if any reductions have occurred due to previous inconsistent performance of her prescribed program. Regarding R165, she was referred to and continues to receive therapy three times per week for her wrist fracture and is progressing. Actions taken to identify other potential residents having similar occurrences: All residents with contractures have been reviewed for proper identification on the MDS and care plan interventions. All residents with contractures are identified	

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F 688	Continued From page 24 trained medication aid (TMA)-E stated R65 walked to the scale to get weighed, and that was the only exercise she was aware of. During an interview on 9/15/21, at 1:59 p.m. when asked about exercises for R65, nursing assistant (NA)-F removed a task list from her pocket and pointed to a task which indicated "Complete upper extremity ROM HEP (home exercise program) with assist from nursing 2 times per day, 10-20 reps each." NA-F had not done these exercises with R65 as she did not usually work on R65's unit. During an interview on 9/15/21, at 2:07 p.m. (TMA)-D stated she was not aware of ROM exercises to be done for R65's upper extremity, but was aware of ambulation as an exercise and stated they did that. During an observation and interview on 9/16/21, at 8:26 a.m. was sitting in her room in her wheelchair eating breakfast. R65 again confirmed no one helped her with exercises to her left upper extremity. During an interview on 9/16/21, at 9:05 a.m., occupational therapist (OT)-E stated R65 had pretty bad contractures of her left elbow, wrist and hand when she arrived at the facility, adding "and it's maybe gotten a little worse." OT-E stated OT had worked on ROM and stretching out R65's upper extremity. When R65 was discharged from OT, OT-E stated nursing continued the ROM. OT-E stated OT did not check to see if nursing continued ROM as recommended. OT-E provided a carbonless quarter slip of paper titled: "PT/OT/ST communication form from OT to nursing" dated 3/11/20, which read: R65 to	F 688	on the Nursing Assistant Care Sheets with relevant interventions noted. All residents with therapy orders have been processed. Measures put in place to ensure deficient practice does not occur: Regular periodic interdisciplinary meetings on each neighborhood will include discussions on noted reductions in function, mobility or ROM. Those identified as having reduced mobility or ROM will be referred to therapy or physician for appropriate interventions. All residents with contractures will be periodically assessed by a licensed therapist for a thorough assessment of their contracture status. Facility policy Range of Motion- Identification of Declines and Interventions Guidance has been updated to reflect the monitoring of ROM programming completion by licensed nursing and therapy demonstration for staff if needed. Staff have been re-educated on identifying, reporting, and treatment of reductions in joint mobility as well as resources available to them should they be unfamiliar with a particular program. Staff responsible for processing therapy orders have been retrained on proper identification and order processing. Effective implementation of actions will be monitored by: Clinical Managers will monitor facility procedures and follow-up as indicated. Nursing Administration and/or designee will audit completion of two ROM programs each week for one month and then audit two ROM programs every other week for two months noting any concerns	

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F 688	Continued From page 25 complete UE ROM HEP (upper extremity range of motion home exercise program) with assistance from nursing; 1-2 x/day, 10-20 reps each. OT-E stated this form went to nursing when a resident was discharged from OT. When asked if nursing staff knew how to do the ROM exercises, OT-E stated, "They should. If they don't, they would call and ask us." An OT discharge note dated 4/1/20, indicated R65 had participated in five OT sessions to address her left upper extremity contracture and R65 was provided with the ROM HEP in order to reduce risk of contracture. The note further indicated R65 was educated in each exercise and verbalized understanding, but due to cognitive impairment, nursing should assist as needed in order for R65 to initiate. During an interview on 9/16/21, at 10:31 a.m., when asked what kind of exercises he assisted R65 with, (TMA)-C stated he walked R65, weighed her and cleaned her up. TMA-C was not aware of exercises other than walking. During an interview on 9/16/21, at 10:48 a.m., registered nurse (RN)-B was asked if nursing assisted R65 with any type of exercises. RN-B stated R65 walked with a cane for exercise. RN-B was informed that R65 had UE ROM exercises listed on her care plan, but R65 stated she wasn't receiving them and staff stated they weren't doing them. RN-B stated she would check into it, adding "R65 isn't going to lie; if she says she's not getting them, she's not getting them." During an interview on 9/17/21, at 10:27 a.m., TMA-D was asked if she assisted R65 with exercises. TMA-D stated yes and removed a sheet of paper from her pocket on which left	F 688	and making corrections as necessary. Those responsible to maintain compliance will be: Director of Nursing will review the audit information, concerns noted and corrective actions taken, compiling the information before presenting to the monthly Quality Assurance Committee meetings for discussion. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions. Completion date for certification purposes only is 10-22-21.	

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upper extremity exercises was listed, and in which TMA-D had highlighted in yellow. TMA-D had written notes on the sheet indicating she had done exercises with R65 on 9/17, at 7:23 a.m.

During an interview and observation on 9/17/21, at 10:32 a.m., R65 was sitting in her wheelchair in her room. R65 was asked if staff were doing left arm exercises with her and she replied, "Yes, they just started today."

During an interview on 9/17/21, at 10:44 a.m., RN-A stated after conversation on 9/16, she looked at the task sheet, thinking she would have to add exercises for R65, but discovered exercises were already on the task sheet. RN-A stated she talked to TMA-C and asked what he did for exercises with R65. TMA-C told her he only walked her and did not do left arm exercises because he was afraid, but never told anyone. On 9/17, RN-A stated she went into R65's room with TMA-D and guided TMA-D through the UE exercises. TMA-D told RN-A she didn't do the UE exercises because she was afraid she would hurt R65 due to the severity of her contractures. RN-A was asked to provide documentation of UE exercises being performed with R65. Exercises were documented as being done twice a day for the past 29 days from 8/19/21, through 9/16/21, (with the exception one day/one time on 9/13). When asked how it was possible that UE exercises where documented as being done twice a day, despite R65 stating they were not being done and staff admitting they were not doing them? RN-A she didn't know..."I can't explain it. This resident is oriented...if she says it's not being done, I believe her."

During an interview on 9/17/21, at 12:25 p.m. the

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F 688	Continued From page 27 director of nursing (DON) stated he would expect nursing to perform ROM exercises with a resident if it was care planned. DON was informed of findings, including documentation that UE ROM was being performed despite R65 stating it was not being done and nursing staff stating they were not performing it. In addition, the DON was informed this was verified by RN-B. R168 R168's face sheet printed on 9/16/21, indicated R168 was admitted on 8/5/2020, diagnoses included fracture of left radius (forearm bone), fracture of cervical vertebra (spine of the neck), pain, epilepsy (seizure disorder), and carpal tunnel (nerve compression of wrist). R168's significant change Minimum Data Set (MDS) assessment dated 8/30/21, indicated R168 was cognitively intact, one-person physical assist with transfers, dressing, toilet use, and bathing, functional limitation in range of motion of upper extremity, used walker and wheelchair, recent surgery, and orthopedic surgery repair of bones. R168's care plan printed on 9/16/21, indicated self-care deficit related to impaired mobility due to recent L (left) wrist fracture ORIF 8/16/21 and interventions included. assist of 1 with dressing, grooming, and bathing and a nurse needs to monitor my skin condition and make referrals as needed.	F 688		

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On 9/14/21, at 9:44 a.m. R168 was seated in a recliner with a split on her left wrist. R168 stated she fell at the facility five weeks ago, broke her wrist, and had surgery. R168 stated the doctor wanted her to do therapy and exercise after surgery, but she had not started the therapy yet. R168 further stated she completed left wrist exercises herself and received no assistance from staff or therapy with the exercises. R168 removed her splint from her left wrist and opened and closed her hand and stated her doctor wanted her to move her hand often like this.

R168's pre-op history and physical dated 8/9/21, indicated on 8/4/21, R168 fell in her bathroom at the facility and fractured her left distal radius. The physician notes further stated, ORIF [open reduction and internal fixation](surgery used to stabilize and heal a broken bone) of intra-articular distal radius fracture [bone at the wrist] was recommended and R168 was cleared for surgery.

R168 appointment referral dated 8/16/21, indicated L[left] wrist ORIF and provider order directed to keep dressing in place and dry f/u [follow up] in 7-10 days.

After Visit Summary (AVS) for R168 dated 8/16/21, after care instructions included follow up with physical therapy appointment, make appointment to start hand therapy in 3-5 days.

R168's physician order dated 8/31/21, indicated 1. May wash hand/arm PRN [as needed] 2. Encouraged to come out of splint frequently for bathing/therapy 3. Aggressive AROM/PROM [active range of motion/passive range of motion] therapy 4. Recommend 1-2 visits/week in occupation hand therapy clinic 5.RTC [return to

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F 688	Continued From page 29 clinic] 3w [week] On 9/17/21, at 8:00 a.m. an interview with registered nurse (RN)-G stated the resident had not received PT after her surgery on 8/16/21. RN-G verified and confirmed the AVS on 8/16/21, indicated R168 doctor orders were to follow up with PT and RN-G stated the heath unit coordinator (HUC) was responsible to enter the orders. RN-G further verified the HUC should have made R168's appointment for PT. RN-G stated the HUC responsible for entering order was no longer employed at the facility and she was not the nurse for the resident at the time the order was received. RN-G stated an appointment was made yesterday for the resident and she would ensure the resident attended PT today. On 9/17/21, at 8:30 a.m. an interview with R168 stated the facility made her an appointment for PT and she would attend today. On 9/17/21, at 8:04 a.m. nursing assistant (NA)-G stated the only range of motion (ROM) R168 received was on her lower extremities and confirmed no upper extremity range of motion was completed. On 9/17/21, at 10:11 a.m. an interview with the director of nursing (DON) confirmed the post-surgery doctor order on 8/16/21, for PT should have been entered and would expect the resident to have received PT already if she did not refuse. The DON stated he would investigate and further stated the HUCs entered the orders and a resident with a fracture were expected to follow doctor orders for physical therapy. On 9/17/21, at 11:51 a.m. a follow up interview	F 688		

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with the DON stated and confirmed R168 had not received PT or OT or offered an appointment. The DON verified R168 appointment should have been made and offered. The DON stated the resident had been doing self ROM and would see PT today.

Facility policy titled Range of Motion, with revised date of 8/2016, indicated:
A resident with a limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. The guidelines were to ensure that a resident reached and maintained his or her highest level of range of motion and to prevent avoidable decline in range of motion. The guidelines indicated that a licensed therapist would evaluate quarterly to determine if the contracture is stable, improving or worsening. Weekly issues related to reductions in ROM were reviewed at neighborhood Interdisciplinary Team meetings (IDT). Therapy would communicate their findings and recommendations to the nursing department via the internal communication tool. Nursing would initiate or update the care plan, update the NA assignment sheet for ROM, create a Point of Care task in the electronic medical record, and create a treatment record for nursing to monitor the completion of ROM programing. If a resident or decision maker refused ROM, the care plan would be updated. All restorative nursing programming was completed by nursing, and restorative nursing techniques were included in new hire orientation.

Facility policy titled Practice Guideline and Procedure: Processing Provider Orders dated 6/2016, indicated:
Purpose: Assure the timely processing and

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F 688	Continued From page 31 implementation of provider orders. Provider orders include all medications, treatments, procedures that provide the well-being of the resident, limitation of activities, use of restraints, diet, level of care, rehabilitation potential, health care directives, discharge plan, signed and dated by the attending Policy: -All orders will be retained in their resident's chart in reverse chronological order and will be signed by the physician. -Orders may be taken by licensed personnel only. -Nurses are responsible for seeing that orders are complete with level of care, rehab potential, diet allergies etc. S/he obtains completion within 24 hours of admission or as soon as reasonably feasible after weekend/holiday admission. Admissions can be processed from fax copies assuring that when the originals arrived in the facility the nurse then cross checks from fax orders to the original.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure CPAP (continuous positive airway pressure) was utilized	F 695	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	10/22/21

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F 695	Continued From page 32 in accordance with physician orders, and that associated supplies were available to meet the individual needs for 1 of 1 residents (R149) reviewed for respiratory care and services. Findings include: R149's facesheet printed on 9/16/21, indicated diagnoses of obstructive sleep apnea (sleep-related breathing disorder which causes a person to repeatedly stop and start breathing while sleeping), dependence on other enabling machines and devices (CPAP), and obesity. R149's admission Minimum Data Set (MDS) assessment dated 8/9/21, indicated R149 was cognitively intact, hearing and vision were adequate, clear speech, was able to make self understood and could understand others. The MDS indicated "no" for non-invasive mechanical ventilator such as CPAP. R149's plan of care did not include CPAP. Physician orders all dated 8/19/21, and related to CPAP indicated: 1. Set up CPAP tubing filter and mask every evening. Apply to residents face/head. ---From 8/19 through 8/30, R149's treatment administration record (TAR) indicated CPAP was applied at every bedtime with the exception of 8/22 (reason not indicated), and refusals on 8/29 and 8/30. ---From 9/1 through 9/15, the TAR indicated CPAP was applied only once on 9/4. The rest of the dates were documented as refusals. 2. Tubing: in the morning every seven days, wash CPAP tubing with soap and water weekly. Hang over bathroom towel to dry.	F 695	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F695 It is the policy of Lyngblomsten that a resident who needs respiratory care is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. To assure continued compliance the following plan has been implemented: Regarding cited residents: With respect to resident R149, the resident has had the order for her continuous positive airway pressure (CPAP) discontinued pending an assessment by her sleep specialist for mask fitment and continued CPAP use (resident had not seen sleep specialist since 2015 and new orders/equipment could not be obtained until seen). Actions taken to identify other potential residents having similar occurrences: All residents who receive respiratory services could be affected by a similar delay in identifying and correcting complications in the delivery of a prescribed treatment. Measures put in place to ensure deficient practice does not occur:	

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F 695	Continued From page 33 ---The TAR indicated this was done at weekly intervals on 8/27, 9/3, 9/10. 3. Filter: in the morning every seven days, wash CPAP filter with soap and water weekly. Place on towel on night stand to dry. ---The TAR indicated this was done at weekly intervals on 8/27, 9/3, 9/10. 4. Mask: in the morning, wash CPAP mask with soap and water every morning. Place on towel on night stand to dry. ---The TAR indicated this was done daily from 8/20 through 9/16 with the exception of 9/10, and indicated the mask was cleaned on mornings when R149 did not use the mask/CPAP. Furthermore, the mask was never seen during observations from 9/14 though 9/16. 5. Water reservoir: fill CPAP water reservoir every HS (at bedtime) with distilled water to fill line. ---The TAR indicated this coincided with the dates when the CPAP was documented was applied. Nursing progress notes from admission on 8/3/21, through 9/15/21, do not mention CPAP utilization or issues related to R149's discomfort with the mask. R149's history and physical completed by a nurse practitioner and dated 8/5/21, indicated history of sleep apnea and uses CPAP, with plan to continue with CPAP. During an interview and observation on 9/14/21, at 9:47 a.m., a Phillips brand Respironics System One CPAP machine and tubing were observed on R149's small bedside dresser. R149 stated she had not used it for awhile, adding "I need to get back to using it though." No mask was visible on bedside dresser or in bathroom.	F 695	All residents who currently receive respiratory treatments have been reviewed and no complications in delivery of treatments have been identified. Staff have been trained on steps to take when complications in the delivery of a respiratory treatment is identified, such as: • Investigate the cause of the complication (e.g. resident refusal, equipment availability, equipment malfunction, etc.) • Resolve the cause of the complication (e.g. counsel the resident on the risk/benefits of treatment, contact vendor to secure/replace equipment, contact central supply for supplies, etc.) • Contact the provider for guidance (e.g. alternative treatment if refusing, discontinuing if not necessary, etc.) • Notify Nursing Administration for guidance Residents who receive respiratory services will be periodically reviewed by the Clinical Management team for compliance and continued need for services will be discussed with the residents' provider. Effective implementation of actions will be monitored by: Nursing Administration and/or designee will audit the delivery of respiratory services to three residents a week for one month then every other week for two months. Nursing Administration and/or designee will note any concerns and make adjustments as needed to assure compliance. Those responsible to maintain compliance	

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F 695	Continued From page 34 During interview and observation, on 9/15/21, at 11:30 a.m., R149 stated she could not recall the last time she wore CPAP. R149 admitted she should wear it but it was uncomfortable and she often declined to wear it. R149 stated no one had asked her about trying a different style mask that would be more comfortable. During an interview on 9/16/21, at 12:00 p.m., nursing assistant (NA)-G stated she was familiar with 149's CPAP and that nurses took care of it. NA-G didn't know if R149 used it or not, but had never seen her with it on. NA-G looked for the CPAP mask in R149's room and was not able to find it. During an interview on 9/16/21, at 12:05 p.m. with registered nurses (RN)-C and (RN)-E, RN-C stated R149 did not use her CPAP because R149 said it was uncomfortable. RN-E stated "I've never taken it off her in the morning; I don't think she uses it." RN-E stated if R149 didn't want to use it or wasn't intending to use it, they should talk about discontinuing the order. When asked if CPAP should be listed on R149's care plan and MDS, RN-E stated yes, isn't it? Informed it was not. RN-E stated (RN)-D would be responsible for that. During an interview on 9/16/21, at 12:43 p.m., RN-E stated she spoke to R149 and R149 told her she hasn't been wearing it due to dental work that was making it uncomfortable, but that she wanted to wear it. RN-E added, "And her doctor said she should be wearing it." RN-E stated they would try it that night and would get a different mask if needed so R149 could tolerate it, adding "no one had investigated why she wasn't wearing it -- I got to the bottom of it."	F 695	will be: Director of Nursing will review the audit information, concerns noted and corrective actions taken, compiling the information before presenting to the monthly Quality Assurance Committee meetings for discussion. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions. Completion date for certification purposes only is 10-22-21	

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F 695	Continued From page 35	F 695		

During an interview on 9/16/21, at 1:07 p.m., when asked how she became aware of equipment that a resident arrived with on admission, RN-D stated there was a process they followed, adding when R149 was admitted on 8/3/21, she did not have an order for CPAP. RN-D stated R149 went for surgery on 8/16/21, and when she returned on 8/18/21, she had the order for CPAP. RN-D admitted she did not look at the orders when R149 returned from the hospital as there wasn't a significant change..."so I didn't pick up on it. We will assess her for a new mask." RN-D did not know why R149's CPAP wasn't communicated to her at weekly IDT meetings.

During an interview on 9/17/21, at 10:15 a.m., R149 stated someone mentioned getting a new CPAP mask for her. R149 stated "I know I need to start using it again." When asked how she slept at night, R149 stated "not very good...on and off" and that she was tired during the day, sometimes needing to lay down for a nap.

During an interview on 9/17/21, at 10:18 a.m., RN-E stated when she arrived to work that morning, R149 was was wearing CPAP, however R149 told her is wasn't very comfortable. RN-E stated after R149 got her tooth pulled, she would have her fit for another mask. When asked if there was a different style of mask R149 could try now that wouldn't bother her mouth, RN-E stated "I don't know. I need to look into that."

During an interview on 9/17/21, 12:21 p.m., the director of nursing (DON) was informed of this occurrence. DON stated he would expect staff to look for another mask that was more comfortable

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F 695	Continued From page 36 for R149, and if she refused after that to inform the provider. DON was aware RN-E is looking for a different mask. Facility policy titled Continuous Positive Airway Pressure (CPAP), with revised dated of 4/2017, indicated: CPAP improved oxygenation in residents with sleep apnea and promoted resident comfort and safety. The policy included requirement for a physician order, general information, equipment, procedure and documentation, but did not address exploring a residents persistent refusal to utilize CPAP.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		10/22/21

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F 812	Continued From page 37 Based on observation, interview, and record review the facility failed to ensure foods were served under sanitary conditions, hair secured with hairnets during food service, proper glove use and hand washing technique during food preparation, and maintain the ice machine to prevent potential contamination. This had the potential to affect 204 residents of the facility who received food and ice from the kitchen and neighborhood kitchenettes. Findings include: On 9/13/21, at 5:10 p.m. observed unidentified staff enter and exit the 3rd floor neighborhood kitchenette and failed to wash hands or wear hairnets. The staff were further observed to bring uncovered desserts and beverages to the resident's rooms. On 9/13/21, at 5:10 p.m. a unidentified NA (nursing assistant) was observed on the fourth floor kitchenette with no hairnet worn as she stocked the refrigerator. Additionally, a NA was seen with a hair covering, but 4 inches of hair was unsecured as she prepared resident food trays behind the kitchenette counter. On 9/13/21, at 5:20 p.m. NA-A was observed to assist a resident at the dining table, then proceed to remove gloves, prepared another resident soup, touched the microwave, applied a new pair of gloves, and failed and to complete hand hygiene throughout the observation. On 9/13/21, between 5:28 p.m.-5:44 p.m.. unidentified NA's were observed on second floor to deliver 5 meal trays to resident rooms and failed to cover beverages and desserts and failed	F 812	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F812 It is the policy of Lyngblomsten that the facility store, prepare, distribute, and serve food in accordance with professional standards for food service safety. To assure continued compliance the following plan has been implemented: Regarding cited residents: All dishwashers have been run, checked and are operating at proper sanitizing temperatures. All ice makers in the facility have been cleaned. All ice maker filters have been replaced per manufacturers recommendations. Actions taken to identify other potential residents having similar occurrences: All residents can potentially be affected by deficient practice related to food service. Measures put in place to ensure deficient practice does not occur: Staff have been retrained on safe and proper food service. Facility has standardized and labeled the location of PPE for meal service (hairnets and gloves) so staff can find and quickly access the necessary protective	

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F 812	Continued From page 38 to wash hands when they entered and exited the kitchenette. On 9/13/21, at 5:31 p.m. observed first floor dining room supper meal and four unidentified NAs served and prepared food for the residents and failed to wear hairnets in the neighborhood kitchenette. On 9/14/21, at 9:53 a.m. observed a unidentified NA make toast for a resident, butter and cut toast with a knife and handled food without gloves. On 9/14/21, at 11:43 a.m. observed the fourth floor neighborhood kitchenette and observed a undaunted NA in the kitchenette with no hairnet worn. On 9/14/21, at 12:12 p.m. observed 300 unit lunch meal and a unidentified NA prepared and served food without a hairnet. On 9/14/21, at 12:14 p.m.. fourth floor NA-H was observed in the kitchenette without hair net On 9/15/21, at 11:55 a.m. dietary aide (DA)-A stated the temperature of the dishwasher on Lund south was not checked daily. DA-A stated she delimed the dishwasher on Mondays, but did not check the temperatures of the dishwashers and further stated she had never checked the temperatures of the dishwashers. On 9/15/21, at 12:04 p.m. maintenance employee (ME)-A observed the 3rd floor dishwasher and explained the dining staff were expected to ensure the dishwasher was above 180 degrees to ensure the dishes were sanitized.	F 812	equipment. Staff have been trained on the proper donning of hairnets with specific instruction given for particular hair types/styles (long/short, etc.). Signs have been placed in each kitchenette area, reminding staff to wear hairnets when serving food, donn gloves when touching food, and wash hands before and after gloving. Staff have been retrained on covering food, including beverages, when transporting food outside of the serving area (e.g. to a resident room), proper supplies have been made available in each kitchenette to aid in easy efficient covering (e.g. cling wrap to cover cups, plate and bowl covers). Dining services has been retrained on proper use of dishwashers with scheduled periodic checks for proper sanitizing temperatures and all staff who use the dishwashers have been trained on proper dishwasher temperatures and how to recognize if the dishwasher is not functioning properly and who to notify if so noted. Maintenance will continue to change the filters of the ice machines, and will log change dates for record. Housekeeping will develop a schedule and periodically clean the ice machines and log those cleanings. Effective implementation of actions will be monitored by: Nursing Administration will oversee the training of staff. Nursing Administration and/or designee will audit meal service three times per week, varying location and meal times, to assure compliance with safe meal service for one month and then three times every other week for two months. Dining Service Director and/or	

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F 812	Continued From page 39 On 9/15/21, at 12:13 p.m. on the second floor kitchenette an unidentified NA was observed with no hairnet worn and beverages and desserts were uncovered when delivered to the residents rooms. On 9/15/21, at 12:29 p.m. a unidentified cook on second floor was observed in the kitchenette and prepared food with no hair net worn. On 9/15/21, 3:15 p.m. an interview with the dietary director (DD) stated she was not aware of a policy for dishwashing temperatures on the neighborhood kitchenette and if the dishes were observed with no debris and steam coming off, the dishes were assumed cleaned. DD further stated the staff in the kitchenettes did not record or take the temperatures of the dishwasher. The DD was not aware when the ice machines were cleaned last and stated maintenance was responsible for the cleaning of the ice machines. The DD stated staff were expected to wear hairnets in the kitchens and kitchenettes, and further stated handwashing was expected prior to entering the kitchenettes. The DD confirmed she was aware not all staff wore hairnets in the kitchenettes and observed food delivered uncovered to the resident's rooms. The DD stated she would educated dietary staff of sanitary practices. On 9/16/21, at 12:53 p.m. observed third flood kitchenette and a unidentified NA with no hair net worn as she prepared resident's food. On 9/16/21, at 1:00 p.m.. ME-A confirmed the ice machines had not been cleaned and stated the filters were changed routinely, but was not able to provide dates.	F 812	designee will audit dishwasher temperature recordings weekly for three months. Director if Housekeeping and/or designee will audit ice machine cleaning weekly for three months. Director of Maintenance and/or designee will audit ice machine filter changes weekly for three months. Those responsible to maintain compliance will be: Directors of Nursing, Dining Services, Housekeeping and Maintenance will review their respective audit information, concerns noted and corrective actions taken, compiling the information before presenting to the monthly Quality Assurance Committee meetings for discussion. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions.	

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F 812	Continued From page 40 On 9/17/21, at 3:00 p.m. housekeeping (H)-A staff confirmed the ice machine had not been cleaned since the remodel of the kitchenette in 3/2020. On 9/17/21, at 7:53 a.m. observed the third floor kitchenette and a trained medical assistant (TMA)-F with no hairnet assisted residents with the breakfast meal, prepared, and served food . TMA-A was further observed to enter the kitchenette touched a pen, failed to wash hands, with her bare finger touched a cooked egg for warmth, delivered a meal tray to a resident room, reentered the kitchenette, and failed to wash her hands. On 9/17/21, at 11:00 a.m. an interview with the administrator stated dietary staff were expected to follow the facility policy and procedure for meal service, wear hairnets, wash hands, and maintain equipment. Policy titled Meal Service and Preparation in the Neighborhood/Culinary Services kitchen dated 1/9/17, indicated: Purpose: to provide a warm and inviting home like centered dining experience that encourages choices and stimulates the senses to enhance nutritional, social, and physical well-being. Procedure: 1. Wash hands thoroughly with soap and water before food preparation or service 4. When cart arrive from the main kitchen, assist with placing food in the steam table check and record food temperatures on a random basis. 8. Apply hairnet is preparing and/or dishing up food. Restrain all hair away from your face. Wash her hands after applying near her net. Do not	F 812		

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F 812	Continued From page 41 touch her hair during meal service or preparation. 9. Dish up food selections using required utensils and considering resident preferences. Gloves may be worn only if it's not practical to use utensils. Gloves must be removed in hands wash between clean and dirty activities, such as opening drawers' cupboards and refrigerator Guidelines for preparing serving feeding residents in a sanitary manner using good infection control practices: Cooking and preparing and dishing up food in a sanitary manner : - Wash your hands with soap and water when entering the kitchen do not use hand sanitizer in the neighborhood kitchen. - If you touch anything that's considered dirty, such as residents wheelchair Walker cupboard drawer refrigerator you must wash your hands again before preparing or serving food/fluids. - If you touch something dirty or contaminate your hands such as sneeze cough touch your hair pick an item up the floor opened a cupboard drawer, reposition a resident, hug or shake a resident's hand or administer medications you must wash their hands before preparing or serving food/fluid. - Apply hairnet immediately wash your hands be sure all hair is covered no stragglers - Use utensils to serve all food items -it is more efficient and less confusing as to when to remove them and wash their hands. never touch ready to eat food with their bare hands - You may prefer to wear gloves or preparing serving certain foods, but you must be sure to remove your gloves and wash your hands afterwards - While dishing up food be sure to wash your hands between touching clean and dirty items,	F 812		

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	245347	A. BUILDING _____ B. WING _____	C 09/17/2021

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F 812	Continued From page 42 such as counter, the diet book computer screen that pen clipboard used when checking the food temperature - Remember to use good infection control practices while handling plates cups and silverware picture you hold the handle of the cup bottom the plate and handle of the silverware when - When filling a glass or pitcher with ice, good infection control techniques must be used to prevent the spread of infection. The ice chest and scoops should be cleaned weekly per policy and the scoops should be in a covered container. Policy title Ice chests and machines-Cleaning Policy and Procedure dated 2/2010, indicated - Housekeeping will clean and sanitize the ice cube machines per manufacturers recommendations, semiannually, utilizing the cleaning and sanitizing procedures listed in the products operators manual. Policy titled Machine Dishwashing dated 11/2016, indicated Procedure: -operate dishwasher according to the manufacturers recommendations. -record the final rinse temperature in the log sheet. Inform supervisor of less than 180 degrees. - air dry all pots and pans and utensils.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		10/22/21

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F 880	Continued From page 43 comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the	F 880		

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F 880	Continued From page 44 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate infection control techniques were followed for 1 of 2 residents (R200) observed during catheter care. Findings include: R200's quarterly Minimum Data Set (MDS) assessment dated 8/25/21, indicated the resident had severe cognitive impairment, was dependent on staff with transfers and eating, and required extensive assistance with bed mobility, locomotion on the unit, dressing, toilet use, and personal hygiene. The MDS further indicated R200 had an indwelling Foley catheter (closed sterile system, with a tube inserted into the	F 880	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F880 It is the policy of Lyngblomsten Care Center that the facility establish and	

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F 880	Continued From page 45 bladder and left in place in drain urine). R200's care plan last revised 9/13/21, indicated the Foley catheter had been reinserted on 7/21/21, due to retention of urine. Interventions included to keep the urinary drainage bag and tubing off the floor at all times to prevent contamination and damage. On 9/14/21, at 9:19 a.m. R200 was observed lying in bed; his large catheter drainage bag was laying on top of the floor mat beside the bed. Licensed practical nurse (LPN)-A was in R200's room at that time gathering supplies to empty the drainage bag. At 9:21 a.m., LPN-A was observed emptying R200's urinary drainage bag into a graduate container. Once the the bag was empty, LPN-A clamped the tubing on the bottom of the bag and inserted the tube into the enclose port to keep the tube covered. LPN-A did not use an alcohol wipe to clean off the end of the tubing prior to inserting into the port. When interviewed on 9/14/21, at 9:27 a.m. LPN-A confirmed he had not cleansed the tube on R200's catheter drainage bag with alcohol after emptying. LPN-A stated he had cleaned the tubing when in R200's room earlier but didn't drain the bag at that time. When interviewed on 9/17/21, at 9:29 a.m. registered nurse (RN)-D confirmed staff should be cleansing the drainage tube on urinary catheter bags with an alcohol wipe after emptying the bag and placing the tube back into the port. RN-D further confirmed the catheter bag should not be on the floor. When interviewed on 9/17/21, at 10:39 a.m. the	F 880	maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R200, resident catheter has been properly secured to his bedframe when in bed and has been properly drained, per standards of practice. Review of resident condition reveals no negative outcomes from the catheter care protocol violation. Actions taken to identify other potential residents having similar occurrences: All residents who receive catheter care are at risk from a catheter care protocol violation. Measures put in place to ensure deficient practice does not occur: Root Cause Analysis completed for the catheter care deficiency. All causal factors revealed for the deficient practice were identified and actions implemented to correct. Staff observed for the deficient practice states he understood the proper procedure for catheter care, but admitted he was nervous and had made a mistake while being observed. Staff was coached on promptly admitting making a mistake, and taking corrective actions as soon as possible. All nursing staff have been re-trained on proper catheter care protocols, including the timing of cleansing the catheter drainage port (must be at the time of draining the bag),	

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F 880	Continued From page 46 director of nursing (DON) confirmed he would expect staff to cleanse the tubing of the catheter drainage bag with alcohol prior to reinserting into the port, and further confirmed the drainage bag should not lay on the floor. The policy titled Catheter Care-Urinary Drainage and Leg Bag, revised 5/2018, indicated to keep the drainage bag and tubing off the floor at all times to prevent contamination and damage. The policy further indicated: "7. Remove the drain tube from its holder using an alcohol wipe. 8. Open the clamp and let the urine flow into the graduate container. 9. After the drainage bag is empty, close/clamp the drainage bag. 10. Wipe the drainage tube with an alcohol wipe. 11. Discard alcohol wipe. 12. Replace drainage tube back into its holder."	F 880	additionally, staff were re-trained on placement of catheter drainage bags, that they should be lower that the individuals' bladder (ideally) and fastened securely so they are not able to lay on the floor. Facility policy was reviewed and remains consistent with current requirements and recommendations, no changes were made. Effective implementation of actions will be monitored by: The Infection Preventionist and/or designee will audit catheter cares every shift, every day for one week then decrease frequency as determined by compliance. to assure proper compliance with procedures. Infection Preventionist has and continues to monitor facility infection rates and trends and to date has not identified any concerns related to improper catheter cares. Those responsible to maintain compliance will be: The Root Cause Analysis was reviewed with the Quality Assurance Committee and the Governing Body President. Any ongoing audit data collected will be presented to the Quality Assurance committee by the Infection Preventionist monthly. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		10/22/21

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F 921	Continued From page 47 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dishware were served under sanitary conditions and maintain the kitchen hood in a sanitary condition. This had the potential to affect 204 residents of the facility who received food and ice from the kitchen and neighborhood kitchenettes. Findings include: On 9/13/21, at 2:32 p.m. during the initial kitchen tour with dietary director (DD) and dietary supervisor (DS) the dishroom was observed with a fan on a shelf, that blew throughout the clean side of the dishroom. The fan and fan blades had gray greasy debris that blew on the clean dishes. The DD confirmed the fan was dirty, should not blow on the clean dishes, and staff were expected to remove or clean the fan when dirty. The dishroom findings included: wall vent slates with grease and gray debris, unattached ceiling light above the clean dishes and bugs within the ceiling light. The hood over the stove and ovens was observed to have a significant layer of dust adhering to the filters of the hood. The DD confirmed the filters were dirty and stated the hood was professionally cleaned and maintenance services was responsible for hood cleaning and dietary staff were responsible for the hood vent cleaning. The DD confirmed the hood vents were dirty and expected staff to clean the hood vents weekly.	F 921	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F921 It is the policy of Lyngblomsten that the facility be safe, functional, sanitary, and comfortable for residents, staff and the public. To assure continued compliance the following plan has been implemented: Regarding cited residents: All areas cited in this deficiency have been cleaned and sanitized; hood, hood vent filters, wall filters, fans and lights. Light that was not properly affixed has been secured. Actions taken to identify other potential residents having similar occurrences: All residents can potentially be affected by unsanitary conditions in the facility kitchen area. Measures put in place to ensure deficient practice does not occur: Kitchen staff have been re-trained on	

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F 921	Continued From page 48 The hood vent invoice dated 1/18/21, from the contracted vendor indicated the exhaust hood filters were cleaned 1/18/21. On 9/17/21, at 11:00 a.m. an interview with the administrator stated dietary staff were expected to follow the facility policy and procedure for meal service, wear hairnets, wash hands, and maintain equipment. Policy titled Machine Dishwashing dated 11/2016, indicated Procedure: -operate dishwasher according to the manufacturers recommendations.	F 921	proper hood vent cleaning- methods and frequency. Logs have been established for staff to document cleanings. Director of Culinary and Nutritional Services will oversee the proper cleaning of hood by maintenance staff and establish a log to document cleanings and assure cleanings are occurring at the determined frequency and as needed. Director of Culinary and Nutritional Services will monitor use of ancillary fans in the kitchen and, if used, they are cleaned periodically as needed to assure they are clean and not causing potential contamination of clean dishes/utensils and/or food items. Effective implementation of actions will be monitored by: Director of Culinary and Nutritional Services and/or their designee will train kitchen staff. Director of Culinary and Nutritional Services and/or their designee will audit cleaning logs for hood vents and hoods and inspect ancillary fans weekly for 3 months. Those responsible to maintain compliance will be: The Director of Culinary and Nutritional Services will present audit data collected noting any concerns or adjustments made to the Quality Assurance Committee. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions.	

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/16/2021. At the time of this survey, Lyngblomsten Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 10/19/2021

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lyngblomsten Care Center is a 4-story building with a full basement. The building was constructed at two different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1976, an addition was constructed to the Southside that was determined to be of Type II(222) construction. Because the original building and the one addition are of the same type of construction, the facility was surveyed as one building.	K 000		

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K 000	Continued From page 2 The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 225 beds and had a census of 208 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain an obvious means of egress per NFPA 101 (2012 edition), Life Safety Code, sections 7.10.8.3.1 and 7.10.8.3.2. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 09/16/2021 between 9:00 AM to 3:00 PM, it was revealed that there are two doors on the 4th floor being secured for the center staircase and are not being used for egress, but are not marked	K 211	K211 To meet the requirements of maintaining an obvious means of egress per NFPA 101, sections 7.10.8.3.1 and 7.10.8.3.2, the doors on the 4th floor that are being secured for the center staircase and not used for egress will be marked NO EXIT. Physical Plant Supervisor will periodically audit for compliance. Date completed by 10-22-21	10/22/21

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K 211	Continued From page 3 NO EXIT. This deficient condition was verified by the Facility Administrator and Facility Maintenance Director.	K 211		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency egress lighting per NFPA 101 (2012 edition), Life Safety Code section 19.2.9.1, 7.9, and 7.9.3. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 09/16/2021, between 9:00 AM to 3:00 PM, it was revealed that the emergency lighting located in the lower level mechanical room is not being tested on a monthly or annual basis. There was no record of this testing being completed. This deficient condition was verified by the Facility Maintenance Director.	K 291	To meet requirements of testing emergency egress lighting per NFPA 101 sections 19.2.9.1, 7.9 and 7.9.3, Physical Plant staff will implement testing and documenting of all emergency egress lighting on a monthly basis. Physical Plant Supervisor will periodically audit for compliance. Date completed by 10-22-21	10/22/21
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm	K 345		10/22/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 4 and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.3, 9.6.1.5 and NFPA 72 (2010 edition), National Fire Alarm, and Signaling Code, section 14.4.5. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/16/2021, between 9:00 AM to 3:00 PM, it was revealed that the facility could not provide a current report on the annual fire alarm system being tested. This deficient condition was verified by Facility Administrator and Facility Maintenance Director.	K 345	K345 To meet requirements of records of National Fire Alarm and Signaling Code, system acceptance, maintenance and testing being readily available per NFPA 101 sections 101, sections 9.6.1.3, 9.6.1.5 and NFPA 72 section 14.4.5, Physical Plant Supervisor will assure the results of this annual testing are readily available following the completion of this annual inspection. Date completed by 10-22-21	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of	K 374		10/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/16/2021**

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K 374	Continued From page 5 egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke compartment doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5, and 8.5.4.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/16/2021, between 9:00 AM to 3:00 PM, it was revealed that there were gaps in the smoke barrier doors that were large enough to allow smoke to pass through. This deficient condition was verified by the Facility Administrator and Facility Maintenance Director.	K 374	K374 To meet requirements of maintaining a smoke compartment per NFPA 101, sections 19.3.7.3, 8.5 and 8.5.4.1, Physical Plant staff will install fire rated door gap seals and apply them to any gaps in smoke compartment doors. Physical Plant Supervisor will monitor for continued compliance on a periodic basis. Date completed by 10-22-21	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For	K 914		10/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/16/2021**

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K 914	Continued From page 6 LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test resident room electrical receptacles per NFPA 99 (2012 edition), Health Care Facilities Code, sections 6.3.3.2 through 6.3.3.2.4, and 6.3.4.1.3. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 09/16/2021, between 9:00 AM to 3:00 PM, it was revealed that the facility did not have a current list of the resident room outlets being tested from 2020 to 2021. This deficient condition was verified by the Facility Administrator and Facility Maintenance Director.	K 914	K914 To meet requirements of all resident room electrical receptacles being tested on an annual basis per NFPA 99, sections 6.3.3.2 through 6.3.3.2.4 and6.3.4.1.3, Physical Plant staff will initiate and complete testing and documentation of all resident room electrical receptacles on an annual basis. Physical Plant Supervisor will audit for compliance on a periodic basis. Date completed by 10-22-21	