DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TJUU

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00501 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) LYNGBLOMSTEN CARE CENTER (L1) 245347 1. Initial 2. Recertification (L4) 1415 ALMOND AVENUE 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55108 009342400 (L2)(L5) SAINT PAUL, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 8. Full Survey After Complaint (1.9)13 PTIP 01 Hospital **05 HHA** 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 09/21/2015 (L34) 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) (L18) _1. Acceptable POC 8. Patient Room Size 237 ___ 9. Beds/Room 5. Life Safety Code Not in Compliance with Program 237 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12) * Code: Α 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)237 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE Date: 18. STATE SURVEY AGENCY APPROVAL Date: Gary Nederhoff, Unit Supervisor 10/05/2015 Kamala Fiske-Downing, Enforcement Specialist PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 09/01/1986 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L24) (L25) (1.41)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 10/07/2015 (L32) (L33)DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245347

October 15, 2015

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

Dear Mr. Heinecke:

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

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

Effective September 15, 2015 the above facility is certified for:

237 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 5, 2015

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

RE: Project Number S5347028

Dear Mr. Heinecke:

On August 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 6, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 2, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 6, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 15, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 6, 2015, effective September 15, 2015 and therefore remedies outlined in our letter to you dated August 21, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Riske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245347	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/21/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
LY	NGBLOMSTEN CARE CENTER		1415 ALMOND AVENUE SAINT PAUL, MN 55108	

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5) Date	(Y4)	Item		(Y5)	Date
ID Prefix	F0221	Correction Completed 09/15/2015	ID Prefix	F0225	Correction Completed 09/15/2015		ID Prefix	F0226		Correction Completed 09/15/2015
	483.13(a)			483.13(c)(1)(ii)-(iii), (c)				483.13(c)		_ _
		Correction Completed			Correction Completed					Correction Completed
ID Prefix Reg. # LSC	F0274 483.20(b)(2)(ii)	09/15/2015	ID Prefix Reg. # LSC	F0323 483.25(h)	_09/15/2015		Reg. #	F0441 483.65		09/15/2015
ID Prefix	F0465 483.70(h)	Correction Completed 09/15/2015	ID Prefix		Correction Completed		ID Prefix	-		
LSC	400.70(11)				- -		LSC			<u> </u>
ID Prefix Reg. #		Correction Completed	Reg. #		Correction Completed					Correction Completed
Reg. #			Reg. #		Correction Completed 					Correction Completed —
Reviewed I	By Rev	viewed By	Date:	Signature of Su	ırveyor:				Date:	
State Agen	cy GD	/kfd	10/05/201	15	18	3623				09/21/2015
Reviewed I	By Rev	viewed By	Date:	Signature of Su	rveyor:				Date:	
Followup t	to Survey Comple 8/6/2015			Check for any Unco Uncorrected Def						NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245347	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 10/2/2015
Name of Facility		Street Address, City, State, Zip Code	
LYNGBLOMSTEN CARE CENTER		1415 ALMOND AVENUE SAINT PAUL, MN 55108	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction Completed				Correction Completed					Correction Completed
ID Prefix	-		09/15/2015				09/15/2015					09/15/2015
•	NFPA 101 K0018				NFPA 101 K0029		-		Ū	NFPA 101 K0033		_
	NUU16			LSO	K0029					N0033		
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix	-		09/15/2015				09/15/2015					
	NFPA 101				NFPA 101				Reg. #			_
	K0038			LSC	K0062				LSC			
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix					ID Prefix			_ `
Reg. #				Reg. #			<u>-</u>		Reg. #			
LSC				LSC					LSC	-		
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix					ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			_
			Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix					ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			
Reviewed I	Ву	Reviewed	Ву	Date:	Signat	ure of Sui	veyor:				Date:	
State Agen	су	GS/kfd		10/05/20			124	124				10/02/2015
Reviewed I	Ву	Reviewed	Ву	Date:		ure of Su	veyor:				Date:	
CMS RO												
Followup t	Followup to Survey Completed on:								Summary of	•		
	8/6/2015				Uncorre	ected Defic	ciencies (CM	IS-25	67) Sent to	the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TJUU Facility ID: 00501

		10 22 001111			EBUNIETHOENET		1 memily 12. 00201
MEDICARE/MEDICAID PROVID (L1) 245347 2.STATE VENDOR OR MEDICAID		3. NAME AND AI (L3) LYNGBLO M (L4) 1415 ALMO	MSTEN CARE			4. TYPE OF AC 1. Initial 3. Termination	TION: <u>2 (</u> L8) 2. Recertification 4. CHOW
(L2) 009342400		(L5) SAINT PAU	L, MN		(L6) 55108	5. Validation	6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey A	
6. DATE OF SURVEY 08/0 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	6/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	NDING DATE: (L35)
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	f The Following Requi	rements:
To (b):			equirements e Based On:		2. Technical Personnel		f Services Limit
12.Total Facility Beds	237 (L18)	1	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical NF)8. Patient F 9. Beds/Ro	Room Size
13.Total Certified Beds	237 (L17)	X B. Not in Con Requirem	npliance with Progents and/or Appli		* Code: B*	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF 237	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Kathy Sass, HFE	NE II		09/30/2015	(L19) K	amala Fiske-Downing, l	Enforcement Sp.	ecialist 10/02/2015 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	STATE AGENCY	,
DETERMINATION OF ELIGIBI	Participate		IPLIANCE WITI HTS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Abov	rol Interest Disclosure S	
22. ORIGINAL DATE	22 IEG AGDEE	MENTE	4 LTC ACREE	(ENT	26 TERMINATION ACTION		(I 20)
OF PARTICIPATION	23. LTC AGREED BEGINNING		4. LTC AGREEN ENDING DA		26. TERMINATION ACTION VOLUNTARY 0		(L30) LUNTARY
09/01/1986	BEGINNING	DAIL	ENDING DA	IL	01-Merger, Closure		to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	0014	l to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHE	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-110	vider Status Change
(L27)	B. Rescind So	uspension Date:	(L44)			00-Act	nve
			(L45)				
28. TERMINATION DATE:	29	9. INTERMEDIARY	CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAL	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	
				l l			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 21, 2015

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

RE: Project Number S5347028

Dear Mr. Heinecke:

On August 6, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: Gloria.derfus@state.mn.us

Phone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 15, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 15, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Lyngblomsten Care Center August 21, 2015 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 6, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

Lyngblomsten Care Center August 21, 2015 Page 5

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 6, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Gary Schroeder, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division Email: gary.schroeder@state.mn.us

Telephone: (651) 201-7205

Fax: (651) 215-0525

Lyngblomsten Care Center August 21, 2015 Page 6

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 09/14/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER SUMMARY STATEMENT OF DEFICIENCES (PA.9) D FREETX TAG INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance with the regulations has been attained in accordance with your verification. F 221 483.13(a) RIGHT TO BE FREE FROM Physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess as potential restraint, the use of swim noodles (commonly used as a swim devices, approximately 2.5 inches in diameter x 5 feet long) to bolster a resident's bed mattress toward the wall, in order to prevent the resident (R61) reviewed for accidents. Findings include: On 8/3/15, at 4/13 p.m. registered nurse (RN)-F stated R61 was unable to get out of bed by) Taging and provided to the compliance of the compl			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION (X3) DATE SURVEY COMPLETED
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY ON LSC DENTIFYING INFORMATION PREFIX TAG PREPIX TAG			245347	B. WING		08/06/2015
FRIEFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance with the regulations has been attained in accordance with your verification. F 221 48.31(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility falled to assess as potential restraint, the use of swim noodles (commonly used as a swim devices, approximately 2.5 inches in diameter x 5 feet long) to bolster a resident's bed mattress toward the wall, in order to prevent the resident from getting out of bed for 1 of 3 residents (R61) reviewed for accidents. Findings include: On 8/3/15, at 4:13 p.m. registered nurse (RN)-F			rer	1	415 ALMOND AVENUE	
The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess as potential restraint, the use of swim noodles (commonly used as a swim devices, approximately 2.5 inches in diameter x 5 feet long) to bolster a resident's bed mattress toward the wall, in order to prevent the resident from getting out of bed for 1 of 3 residents (R61) reviewed for accidents. Findings include: On 8/3/15, at 4:13 p.m. registered nurse (RN)-F	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLÉTION
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physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess as potential restraint, the use of swim noodles (commonly used as a swim devices, approximately 2.5 inches in diameter x 5 feet long) to bolster a resident's bed mattress toward the wall, in order to prevent the resident from getting out of bed for 1 of 3 residents (R61) reviewed for accidents. Findings include: On 8/3/15, at 4:13 p.m. registered nurse (RN)-F It is the policy of Lyngblomsten Care Center that every resident is free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident; s medical symptoms. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R61, the swim noodle used under her mattress has been removed. Her care plan has been		on-site revisit of you validate that substa regulations has bee your verification. 483.13(a) RIGHT T	ur facility may be conducted to ntial compliance with the en attained in accordance with O BE FREE FROM	F 221		9/15/15
by: Based on observation, interview and document review, the facility failed to assess as potential restraint, the use of swim noodles (commonly used as a swim devices, approximately 2.5 inches in diameter x 5 feet long) to bolster a resident's bed mattress toward the wall, in order to prevent the resident from getting out of bed for 1 of 3 residents (R61) reviewed for accidents. Findings include: Based on observation, interview and document It is the policy of Lyngblomsten Care Center that every resident is free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident; s medical symptoms. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R61, the swim noodle used under her mattress has been removed. Her care plan has been		physical restraints i discipline or conver	mposed for purposes of inlineration in many interest in m			
		by: Based on observat review, the facility fa restraint, the use of used as a swim dev inches in diameter a resident's bed matt to prevent the resid 1 of 3 residents (R6 Findings include: On 8/3/15, at 4:13 p	ion, interview and document ailed to assess as potential swim noodles (commonly vices, approximately 2.5 x 5 feet long) to bolster a ress toward the wall, in order ent from getting out of bed for accidents. o.m. registered nurse (RN)-F		Center that every resident is free from physical restraints imposed for purpos of discipline or convenience, and not required to treat the resident; s medical symptoms. To assure continued compliance the following plan has bee implemented. Regarding cited residents: With respect to resident R61, the swim noodle used under her mattress has been removed. Her care plan has been	es al n n een

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

TITLE

Electronically Signed

08/31/2015

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
		245347	B. WING		08/0	06/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		00,2010
LVNODI	OMOTEN CARE OF I	TED.		1415 ALMOND AVENUE		
LYNGBL	OMSTEN CARE CEN	IER		SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	herself. During an observather room on 8/4/15 mattress with cut of addition it was noted noodles laying under mattress on the becausing it to tip town noodles were noted 8/4/15, at 2:22 p.m. laying in bed, leaning side. Her phone (or right side of the bedue to the position to be unable to answer staff to assist her. On 8/5/15, at 9:30 aremained under the mattress was tipped by placement of the mattress. The bedue addition one of the under R61's torso asside. The face sheet in the been admitted to the fall that had resulted fractures. Additional senile dementia, ar A significant change assessment in progression.	ge 1 ion and interview with R61 in at 8:10 a.m. A perimeter ut was observed on the bed. In the determinant of the were two swimers the right side of the determinant of the wall. The swimer the wall. The swimers and the wall. The swimers to be in place again on the wall on the left of the overbed table next to the determinant of the bed, R61 was observed of the warring of the bed. a.m. the swim noodles of the determinant of the bed, R61 was in bed and the determinant of the left (wall side of room) of the was against the wall. In noodles had been moved uppered to prop her over on her the record indicated R61 had no facility on 4/23/15, after a definition of the determinant of the wind of the part of the record indicated R61 had no facility on 4/23/15, after a definition of the part of the record indicated R61 had no facility on 4/23/15, after a definition of the part of the record indicated R61 had no facility on 4/23/15, after a definition of the part of the record indicated R61 had no facility on 4/23/15, after a definition of the part of the	F 2	noodle as a fall prevention in Actions taken to identify oth residents having similar occuse of swim noodles as a faintervention has been disconswim noodles in use have been destroyed. All affected residuals have been updated to removal of swim noodles as prevention intervention. Measures put in place to en practice does not occur: Comanager has been instructed inventory swim noodles. Clicand Supervisors have been eliminate the practice of swimed a fall intervention. Facility himplemented a Physical Devented individual is environment refreedom of movement or not one is body and thereby correstraint. Any method or dedetermined to restrict movements and other required reductions, releases, cainterventions and other required safety: Consent, diagnot trial reductions, releases, cainterventions and other requirecessary under §483.13(a) Effective implementation of monitored by: The Director of Nursing and designee will monitor facility practices, polices and/or profollow-up as indicated.	er potential surrences: The all prevention ntinued. All een removed ply have been dents care reflect the a fall sure deficient entral supply ed to no longer inical Manager educated to m noodles as as vice if any manual anical device, d to an stricts ormal access onsidered a evice ment or will require a all the eses, orders, are plan a	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245347	B. WING		08/	06/2015	
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 221	dysfunction. In add had significant depitrouble concentrating feeling down and diresident had indicated an MDS dated 4/25 the call light, was a extensive assist an two for bed mobility indicated restraint us a two for bed movely demands and had a poconcentrating, moves peaking. The care on Hospice care, a right hip and wrist falls. An intervention bed. A handwritten the fall care plan stoplace on the bed to movements, and in [sic] edge of bed to the fall Report dated stood and walked or room and that she'd then's when I fell	1 had severe cognitive ition, the MDS identified R61 ression due to insomnia, ng, moving or speaking slowly, epressed, and that the ted she'd be better off dead. 15/15, indicated R61 could use thigh risk of fall, and required dweight bearing support of and toilet use. Neither MDS use for R61. 16/16/15/15/15/15/15/15/15/15/15/15/15/15/15/	F 2	Those responsible to maintain will be: The Director of Nursing and/or will complete 3 audits each we month and then 2 audits every week for two months to include compliance with procedures. Collected will be presented to the Assurance committee by the Diversing. The data will be reviewed/discussed at the more Assurance Meeting. At that time Quality Assurance committee with the decision/recommendation any necessary follow-up studies.	designee ek for one other proper he data ne Quality irector of thly Quality e the vill make regarding		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245347	B. WING		08/	06/2015		
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108	, 55,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 221	Continued From pa	age 3 able to verify when the swim	F 22	1				
	noodles had been p "to prevent falls."	placed under R61's mattress						
	resident had been in bed on 5/10/15 at 4 reisdent had fallen. had been identified mobility bars on the a.m. R 61 had also edge of her bed. At a.m., R61 had been	progress notes indicated the found to sit on the edge of her 1:37 p.m. On 5/11/15, the Mobility aides at that time as walker, trapeze, and bed. On 5/13/15, at 4:19 been found sitting on the adagain on 6/17/15 at 6:16 in found sitting up on the bed, dout her Foley catheter hering me."						
		ss note review did not identify e swim noodles had been						
	and lacked docume the swim noodles a	entification of when initiated, entation of any assessment of is potential restraints which the mattress to prevent R61 bed.						
	noodles had been per to give it a lift so she had been found clir times. RN-F stated for a restraint, since swim noodle use as out of bed. It [swim intervention; the lip continues to get our reviewed the chart	om, RN-F stated the swim blaced under R61's mattress e doesn't get out, because she mbing out of bed a couple R16 had not been assessed e the facility didn't view the s a restraint,"she can still get noodle] was put in as an ped mattress first, then if she t, you add the noodles." RN-F with the surveyor and stated, it was started [initiation of						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		COMPLETED	
		245347	B. WING _		08	3/06/2015	
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 221	intervention found (R61) got up and w and fell trying to ge alarm to call light sybed." On 8/4/15, at 2:39 p (DON) stated she, the lipped mattress recommendations further stated, "that think they feel it is a lipped mattress." That if a bed was pustrong side of a rest that could be a form	was on 5/11/15, when she valked over to turn the light off to back into bed, we added Tab ystem and there was a low p.m. the director of nursing "doubted the manufacturer of the or the bed would make for swim noodles." The DON to intervention pre-dates me, I as small little addition to the The DON also acknowledged but up against the wall on the sident who has hemiparesis, in of restraint, but added "If still able to get out of bed. I	F 22	1			
	(TMA)-B stated, "T keep her from goin putting her legs over that. I think it's a nubed, once you put the equipment." When use the swim nood nursing assistant canot here". On 8/6/15, at 11:09 noodles are a fall in box intervention, do long ago. We have noodles are not to be help remind the rest there." RN-G verified even with a lipped in the state of the	a.m., trained medication aide The swim noodles, are used to g over the edge of the bed, by er. I don't know who decides arse order. It just stays on the them on. It's just part of the asked how she would know to les, TMA-B reviewed the are sheets and stated, "oh it's a.m., RN-G stated "the eveloped in a fall conference, used them for a long time, restrict movement, it's just to sident the edge of the bed is ed the noodles could be used mattress, "It's just because ntinue to swing (legs) out of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245347	B. WING		08	/06/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•		
LYNGBL	OMSTEN CARE CEN	TER		1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 221	she would determine was a restraint for a RN-G stated, "that' On 8/6/15 at 2:00 p DON were interview intention was to creat the individual, and in that practice. The cause limited move her body, so we do restraint." However of a circular argum restraint if you don' On 8/6/15, at 4:00 pinformation about to noodles which inclute the rapy, pool noodly routines and rehabe The facility's Restra Procedure was rev "Prior to a restraint restraint assessme Purpose: 1. To evaluate indiviouse of any restraint 2. To protect reside 1.) Data collect following: a. Medical diagon b. Physical c. Cognitive d. Elimination e. Decision f. Behavior 2.) Docume restraints	e surveyor asked RN-G how he whether the swim noodle a resident without assessing, a good question." o.m., the administrator and wed. The DON stated the rate a sense of perimeter for the noodle had been effective a DON said, "A restraint would ament, would limit access to n't view it (the noodle) as a the DON also stated, "It's kind and the that you don't know if it's a transfer assess it." o.m. the DON provided he appropriate use of the uded: hydrotherapy, aquatic es. "For aquatic exercise dilitation." aint Assessment Policy and diewed and included: being applied, a physical not will be performed. Fridual resident' needs prior to int's rights Procedure: ion and analysis of the enosis present Assessment estatus on pattern making skills pattern analysis of alternatives to our times, place of occurrence	F 2	21			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		COMPLETED		
		245347	B. WING			08/	06/2015	
	PROVIDER OR SUPPLIER OMSTEN CARE CENT	rer .		STREET ADDRESS, CITY 1415 ALMOND AVENUE SAINT PAUL, MN 55	E	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 221 F 225 SS=D	type, reason for use check every 30 min hours with position 5. Update care plan 6. Place on the 24 h 7. Review restraint	order for medical diagnosis, e, when to be used, utes and release every two change. I and approaches nours sheet. use " (c)(2) - (4)	F 2				9/15/15	
	been found guilty of mistreating resident had a finding entered registry concerning of residents or misa and report any know court of law against indicate unfitness for	t employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ties.						
	involving mistreatm including injuries of misappropriation of immediately to the ato other officials in a	sure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law I procedures (including to the ertification agency).						
	violations are thoro	ve evidence that all alleged ughly investigated, and must ential abuse while the rogress.						
	The results of all inv	vestigations must be reported						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	LE CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
		245347	B. WING		08/06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE SAINT PAUL, MN 55108	220220
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 225	to the administrator representative and with State law (inclicertification agency incident, and if the appropriate correct		F 225		
	facility failed to ens studies were conduworking independenewly employed en Findings include: Review of new hire 8/6/15 indicated en of 3/10/15. Review Clearance had a state undated Nursin indicated E1's last. Review of new hire 8/6/15 indicated E2 Review of the Backstudy date of 8/4/15 Nursing Departmene E2's last orientation. During an interview director of human reackground check Minnesota Departmene/27/15, 139 days as	w and document review, the ure employee background acted prior to employees ntly with residents for 2 of 5 aployees (E1, E2) reviewed. list provided by the facility on apployee (E)-1 had a start date of the Background Study udy date of 6/30/15. Review of g Department schedule for E1 orientation day was 3/16/15. list provided by the facility on a had a start date of 7/14/15. Is ground Study Clearance had a start date of 7/14/15. Is ground Study Clearance had a start date of 7/14/15. In schedule for E2 indicated and ay was 7/22/15. If on 8/6/15, at 8:13 a.m. the resources (DHR) stated E1's had been submitted to the nent of Human Services on after E1's start date. The DHR ave been trained but would not		It is the policy of Lyngblomsten Card Center that the facility not employ individuals who have been found gu abusing, neglecting, or mistreating residents by a court of law; or have finding entered into State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; at report any knowledge it has actions court of law against an employee, we would indicate unfitness for service and the nurse aide or other facility staff to the State nurse aide registry or licensing authorities. To assure continued compliance the following plan has be implemented. Regarding cited residents: With respect to staff identified, E1 at background studies were completed both were identified as able to provid direct contact services for this facility. Actions taken to identify other potent residents having similar occurrences all employee records were reviewed assure proper background studies we completed. Measures put in place to ensure defined.	ilty of had a e nd by a hich as a e g een nd E2, d and de y, tial s: I to vere

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		[`	(X3) DATE SURVEY COMPLETED	
		245347	B. WING			08/0	06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	The DHR confirmed 3/16/15, and that E unsupervised with a During an interview DHR stated E2's bas submitted on 8/3/15. The DHR verified E residents unsuperv "it would be a late so During an interview director of nursing to background checks prior to either of the independently with "We are down to or resources), it was a The facility's Vulner Policy dated 3/2015 employment in the have the following so "a.) Reference check past employer, b.) a registry check, c.) (CBC) pursuant to Employees, volunte work pending the obe under continuous have access to per results of the CBC employee being incenvironment with viemployment will be	ded "for that length of time." ded E1's last training day was 1 had been working residents since then. on 8/6/15, at 8:57 a.m. the ackground check was 5, 20 days after E2's start date. 2 had been working with ised since 7/22/15 and stated, submission, it was delinquent." on 8/6/15, at 12:27 p.m. the (DON) verified that s should have been completed rese staff being allowed to work residents. The DON stated, he person in HR (human human oversight." rable Adult/Abuse Prevention 5, indicated all applicants for facility should, at a minimum, recreening check conducted: cks with the current and/or Appropriate licensing board or Criminal Background Check facility policy or State law i.) rers and interns may begin recreated with the rerer returned with the religible to work in this religible to work in this religible to work in this reminated immediately."		225	practice does not occur: Staff responsible for completing background studies were re-educate the regulatory requirements. Staff responsible for the assignment and deployment of staff were educated or requirement for background studies facility policy regarding training, supervision and direct contact of new staff. Current tracking system for new hires was enhanced to include background studies as a noticeable requirement for staff involved in the processing, orienting, training, schedand deployment of newly-hired staff. Effective implementation of actions we monitored by: Director of Human Resources will make a facility adherence to practices, police and/or procedures and follow-up as indicated. Those responsible to maintain comp will be: The Director of Human Resources and designee will audit each new hire to include proper compliance with procedures. The data collected will be presented to the Quality Assurance committee by the Director of Human Resources. The data will be reviewed/discussed at the monthly of Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regardany necessary follow-up studies.	on the and w duling, will be onitor es oliance and/or be	
F 226 SS=D	483.13(c) DEVELO ABUSE/NEGLECT		F 2	226			9/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245347	B. WING		08/0	6/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER	1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	policies and proced mistreatment, negl	evelop and implement written	F 226			
	by: Based on interview facility failed to imp policy regarding so newly employed en background checks working with reside. Findings include: The facility's Vulne Policy dated 3/2018 employment in the have the following: "a.) Reference che past employer, b.) registry check, c.) (CBC) pursuant to Employees, volunte work pending the obe under continuou have access to per results of the CBC employee being intervironment with vemployment will be Review of new hire 8/6/15 indicated en	v and document review, the lement their Abuse Prevention reening procedures for 2 of 5 aployees (E1, E2) whose is were not verified prior to ints. Table Adult/Abuse Prevention for indicated all applicants for facility should, at a minimum, is creening check conducted: cks with the current and/or Appropriate licensing board or Criminal Background Check facility policy or State law i.) is ers and interns may begin utcome of the CBC, but must is, direct supervision if they sons receiving services. If the are returned with the eligible to work in this ulnerable adults, their terminated immediately." Ilist provided by the facility on aployee (E)-1 had a start date of the Background Study		It is the policy of Lyngblomsten Car Center that the facility develop and implement written policies and product that prohibit mistreatment, neglect, abuse of residents and misapproprofunce of resident property. To assure concompliance the following plan has limplemented. Regarding cited residents: With respect to staff identified, E1 abackground studies were completed both were identified as able to providirect contact services for this facil Actions taken to identify other pote residents having similar occurrence. All employee records were reviewed assure proper background studies completed. Measures put in place to ensure depractice does not occur: Staff responsible for completing background studies were re-educated the regulatory requirements. Staff responsible for the assignment and deployment of staff were educated requirement for background studies facility policy regarding training, supervision and direct contact of ne staff. Current tracking system for residents.	cedures and iation tinued been and E2, ed and ride ity. Initial es: ed to were efficient ted on the s and ew	

_ ` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING			08/0	06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	the undated Nursin indicated E1's last of Review of new hire 8/6/15 indicated E2 Review of the Back study date of 8/4/15 Nursing Department E2's last orientation. During an interview director of human in background check Minnesota Department 6/27/15, 139 days a verified E1 would have been supervist The DHR confirmed 3/16/15, and that E unsupervised with in During an interview DHR stated E2's basubmitted on 8/3/15 The DHR verified E residents unsupervit would be a late subackground checks prior to either of the independently with	dudy date of 6/30/15. Review of g Department schedule for E1 prientation day was 3/16/15. list provided by the facility on had a start date of 7/14/15. ground Study Clearance had a start date of 7/14/15. ground Study Clearance had a start experience had a start date of 7/14/15. ground Study Clearance had a start experience had a start date of 7/14/15. ground Study Clearance had a start experience had been submitted to the heat of Human Services on after E1's start date. The DHR ave been trained but would not sed "for that length of time." In the start experience had been working exidents since then. If on 8/6/15, at 8:57 a.m. the ackground check was so, 20 days after E2's start date. Start date had been working with his experience had been working with sed since 7/22/15 and stated, submission, it was delinquent." If on 8/6/15, at 12:27 p.m. the (DON) verified that should have been completed as extended have been completed	F 2	226	hires was enhanced to include background studies as a visible requirement for staff involved in the processing, orienting, training, sche and deployment of newly hired staff Effective implementation of actions monitored by: Director of Human Resources will not facility adherence to practices, policity and/or procedures and follow-up as indicated. Those responsible to maintain commodified will be: The Director of Human Resources and designee will audit each new hire to include proper compliance with procedures. The data collected will presented to the Quality Assurance committee by the Director of Human Resources. The data will be reviewed/discussed at the monthly of Assurance Meeting. At that time the Quality Assurance committee will me the decision/recommendation regard any necessary follow-up studies.	eduling, i. will be nonitor es pliance and/or be n Quality enake	
F 274 SS=D		MPREHENSIVE ASSESS	F 2	274			9/15/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245347	B. WING		08/06/2015	
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO	N
F 274	assessment of a refacility determines, that there has beer resident's physical purpose of this sec means a major decresident's status thitself without furthe implementing standinterventions, that hone area of the res	duct a comprehensive esident within 14 days after the or should have determined, in a significant change in the or mental condition. (For tion, a significant change cline or improvement in the at will not normally resolve in the revention by staff or by dard disease-related clinical has an impact on more than ident's health status, and linary review or revision of the	F 27	4		
	by: Based on observareview, the facility for comprehensive assfor 1 of 3 residents identified oral healt facility failed to consignificant change (R178) who was idemprovement in action improvement in action in the second secon	sessment of oral/dental status (R244) reviewed with h concerns. In addition, the aplete comprehensive assessment for 1 of 1 resident entified as having an civities of daily living (ADLs). d on 8/3/15, at 4:00 p.m. to h when he laughed after en asked if he had any wing R244 did not respond, but		It is the policy of Lyngblomsten Car Center that the facility conduct a comprehensive assessment of a reswithin 14 days after the facility determines, or should have determined that there has been a significant chain a resident; sphysical or mental condition. To assure continued compliance the following plan has b implemented. Regarding cited residents: With respect to resident R244, a comprehensive oral assessment has been completed and his diet order a care plan have been updated to refloral status and difficulty chewing. Regarding resident R178 a Significat Change MDS was completed and hiplan updated to reflect his change ir mobility status.	sident ned, ange een s and ect his ant is care	

OLIVILI	IO I OIT WILDIOAITE	A MEDICAID SETTICES			<u> </u>	IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING	i		08/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				14	415 ALMOND AVENUE		
LYNGBL	OMSTEN CARE CEN	TER			SAINT PAUL, MN 55108		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLÉTION DATE
F 274	Continued From pa	age 12	F:	274			
		elchair in the day room.		_, .	Actions taken to identify other pote	ntial	
		approached and asked how			residents having similar occurrence		
		stated "good" and kept his			residents naving similar occurrence		
		asked if he was still tired he			for accuracy. All changes in resid		
		ened his eyes and looked at			mental and physical conditions are		
		d. At the time R244 was noted			reviewed as part of the weekly IDT		
		appeared yellow and the front			process on each neighborhood. A		
		aw appeared broken.			noted changes are analyzed for rec		
		03 a.m. R244 was observed			interventions; assessments, care p		
	eat his breakfast ar	nd appeared to be spending a			updates, physician and/or family		
	long time chewing l	his food and appeared to be			notifications, etc. and appropriate a	actions	
		proximately two to three			taken, including a Significant Chan	ge	
		ach bite compared to the			MDS.		
		ing his front teeth with a lot of			Measures put in place to ensure de	eficient	
		activity. When approached			practice does not occur:		
		food was R244 stated it was			Staff have been re-educated on inf		
	<u> </u>	he needed help to cut up his			appropriate lead personnel on resident		
		n. During the observation			changes; e.g. If a resident has incr		
		erved to have any signs or			difficulty chewing they are to notify		
		or discomfort with either eating			nursing supervisor. Change in cor		
	or drinking.				policy was reviewed with all approp		
	DOMA's Oral Assess	amont completed 7/6/14			staff. A new integrated oral assess		
		sment completed 7/6/14, t have missing natural teeth;			was developed in the facility Electr Health Record allowing coordinate		
		Dental Status section on both			completion by a multidisciplinary te		
	-	nge Minimum Data Set (MDS)			MDS Coordinators have been	alli.	
		ated he had no dental			re-educated on the change require	ments	
		MDS indicated R244 had			that define a significant change.		
		cognition and required			Effective implementation of actions	will be	
		assistance of one staff with			monitored by:		
		e Care Area Assessment			The Director of Nursing will monito	r facility	
		s, failed to address R244's			adherence to practices, polices and		
		tatus. The facility failed to			procedures and follow-up as indica		
		ssess R244's dental status.			Those responsible to maintain com will be:		
	On 8/5/15, at 10:33	a.m. registered nurse (RN)-A			The Director of Nursing and/or des	ignee	
		MDS coordinator, stated the			will complete 2 audits each week for		
		(RD)-A completed Section			month and then 2 audits every other		
		is in the MDS. When asked if			for two months to include proper		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245347	B. WING			08/0	06/2015
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F 274	visual assessment stated she was goin phone RN-A was or reviewed the signifit 4/1/15, and had not indicated after she indicated she looked assessment from with facility and that the assessment. - At 10:42 a.m. RD-MDS based on the if anything came up dental status it would staff. RD-A acknow MDS based on the 7/6/15, which had in problems yet he has stated she did not contain and would not be a broken or missing the At 10:45 a.m. RN-expected the MDS captured all the der RN-A further stated relay on staff to continterdisciplinary efforms on the morning teeth. NA-A indicated R244's teeth he wood in the result of the morning teeth. NA-A indicated R244's teeth he wood in the significant results and the significant results are significant to the morning teeth. NA-A indicated R244's teeth he wood indicated results are significant results and the significant results are significant results and the	D-A used when doing the oral she looked at surveyor and ng to call the RD-A. On the verheard to indicate she had cant change MDS dated a seen an assessment. RN-A got off the phone RD-A had ad at the nursing oral when resident was admitted to was how she had completed as the action of the phone RD-A had at the nursing oral when resident was admitted to was how she had completed as the action of the nursing oral assessment and of in regards to a change in all does communicated to her by alledged she had completed the Oral Assessment dated andicated R244 had no teeth does not a change in the does not a change in the does not a change in a complete to know if R244 had any seeth. A stated she would have to be accurate and to have not all concerns R244 had if any. I'l sign off on the MDS's and I implete various sections it's an ort." A a.m. nursing assistant (NA)-A assisted R244 with all of his g which included brushing his ed when it came to brushing uld attempt to brush them but	F 2	274	compliance with procedures. The collected will be presented to the Q Assurance committee by the Direct Nursing. The data will be reviewed/discussed at the monthly Assurance Meeting. At that time the Quality Assurance committee will in the decision/recommendation regal any necessary follow-up studies.	uality or of Quality e nake	
	she had to assist h the upper and lowe from her recollectionalways some missi	im more in order to get both r jaws. NA-A further stated in she had noted R244 had ng and/or broken teeth in his sure where and how many.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 274	stated "we have to have to continue to for residents like hi make adjustments' assessment had be and added the facil the assessments to electronic health refriendly to monitor a further stated he w to be accurate and getting or having a all the oral assessments. "Routine dental inspection of the ordiagnosis of dental as needed, dental inspection of the ordiagnosis of dental as needed, dental indicate who in the completing the oral ensured that was condicate the current." According to the Lorent According	director of nursing (DON) do an assessment and we attempt to do assessments m who refuse and have to 'DON acknowledged the oral een missed in the beginning lity was working on getting all o Point Click Care (PCC- ecord) which would be more all the assessments. DON ould have expected the MDS the facility was looking into dental hygienist come in to do ments periodically. licy revised 4/30/08, indicated services" include an annual ral cavity for signs of disease, disease, dental radiographs cleaning" The policy did not facility was responsible for I visual assessment and who ompleted and was accurate to t oral status of the resident. Ong Term Care Facility ent Instrument version 3.0 ober 2014, the steps for ed: int about the presence of	F 27	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING		08/	06/2015	
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F 274	examine for loose and examine for chemoval of denture for adequate assess 4. Conduct exam of cavity with denture applicable. Use a livisualize the back of and feel all oral surtongue, palate, more Check for abnormateeth, or inflamed of assessor should us adequately feel for 5. If the resident is observe him or her partials, if indicated problems or mouth 6. Oral examination uncooperative and oral exam may resimissed. Referral for considered for these who exhibits dental Improvement: R178 was observed dining room. R178 breakfast table and other side of the direction walker. His stature and the gait was stature and	fit. Ask him or her to remove, hips, cracks, and cleanliness. es and/or partials is necessary is sment. If the resident's lips and oral is or partials removed, if ght source that is adequate to of the mouth. Visually observe faces including lips, gums, with floor, and cheek lining. It mouth tissue, abnormal or bleeding gums. The se his or her gloved fingers to masses or loose teeth. Unable to self-report, then while eating with dentures or it, to determine if chewing pain are present. In of residents who are do not allow for a thorough wilt in medical conditions being or dental evaluation should be se residents and any resident or oral issues." I d on 8/5/15, at 8:00 a.m. in the pushed himself away from the it stood up. He went to the ning room to retrieve his was slightly slumped forward eady. R178 ambulated out the	F 274				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 274	identified as having range of motion for The quarterly MDS cognition had impro (cognitively intact). and out of room, lo improved to indepestaff, and eating ha after set up. R178 impairment in function arm. The medical riginificant change improvements R17 and on the unit, eat On 8/5/15, at 2:55 admission and quadocumentation for living and acknowled Significant Changes he had viewed all and with current cochanges. Agreed the on the MDS but proposed the significant changes are the significant characterist for the quarterly MID According to the Local Resident Assessment of the Assessment of the the significant characterist for the proposed in the Local Resident Assessment in a resident in a resident in the resi	dated 6/11/15, indicated oved to a score of 15 R178's ability to walk in room comotion on and off unit had endent without any setup by ad improved to independent was identified as having cional range of motion on one ecord lacked evidence of a MDS being completed for the 8 had with ambulation in room ting, and cognition. D.m. RN-A reviewed R178's reterly MDS's and supporting cognition and activities of daily edged R178 should have had a MDS completed. RN-A stated locomotion as one change, gnition score now he had two nat it was four different areas actically looked at as one. Ilinical record lacked evidence age in status was considered DS on 6/11/15. Dong Term Care Facility ent Instrument User's Manual ast revised on October 2014,	F 27	74		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 274 F 323 SS=E	interdisciplinary rev plan." In addition, a significompleted for improsement in two " - Any improveme functioning area whas Independent, Suassistance since later - Decrease in the number Behavioral symptom and/or the frequence - Resident's decision better; - Resident's incontibuter; - Overall improvem 483.25(h) FREE OF HAZARDS/SUPER The facility must enenvironment remains is possible; and	cant change should be by the care of the care of the followed: of or more of the following: int in an ADL physical are a resident is newly coded apervision, or Limited as assessment; intumber of areas where are coded as being present by of a symptom decreases; on making changes for the mence pattern changes for the ent of resident's condition."	F 274			9/15/15
	by: Based on observative review, the facility for disconnection switch area was activated use. This has the properties of the properties o	ion, interview, and document ailed to ensure the safety the for the stove in the cottage when the stove was not in otential to affect 18 of 18 of 18, R139, R283, R310, R225, R227, R107, R192, R4, R72,		It is the policy of Lyngblomsten Ca Center that the facility ensure that resident environment remains as fi accident hazards as is possible; ea resident receives adequate superv and assistance devices to prevent accidents. To assure continued	the ree of ach	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 323	R4) residents ident Findings include: During a continous 2:28 p.m. to 3:04 p. unit kitchenette was (power on to stove) allow the burners a any resident in the Norway unit: On 8/4/15, at 2:28 p. (RD)-B was observ the Norway unit wit was an undated sig off when not in use - 2:41 p.m. trained washed dishes in s counters and left ki stove unlocked2:44 p.m. nursing kitchenette reached kitchenette with sto -2:51 p.m. NA-E en hands, walked from got ice in a styrofoa to sink, passing sto then left the kitcher stove unlocked3:02 p.m. TMA-C es sink and stove. The -3:03 p.m. registere kitchenette, when h remained unlocked -3:04 p.m. TMA-D e key and locked the	observation on 8/4/15, from m. the stove in the Norway sobserved to be unlocked, which had the potential to and oven to be turned on by area. o.m. registered dietician ed to leave the kitchenette on the stove unlocked. There in on the stove unlocked. There in on the stove to "lock stove." medication aide (TMA)-C ink next to stove, wiped off tchenette at 2:44 p.m. with assistant (NA)-D entered of for something and then left to unlocked. Itered kitchenette washed in the sink, pass the stove and imcup. NA-E then walked back we and filled cup with water nette at 2:54 p.m. with the enters kitchenette walked past is stove remained unlocked. Itered the area the stove in the sink is stove remained unlocked. Itered the area the stove in the sink is stove remained unlocked. Itered the area the stove in the sink is stove remained unlocked. Itered kitchenette walked past is stove remained unlocked. Itered kitchenette and used a stove intered kitchenette and used a	F 323	compliance the following plan has implemented. Regarding cited residents: With respect to the 18 residents lis see below for system changes that assure their safety regarding stove each neighborhood. Actions taken to identify other pote residents having similar occurrence. All cognitively impaired mobile resiwere identified. Each is potentially for injury related to stove use on each neighborhood, see below. Measures put in place to ensure depractice does not occur: The facility has replaced all stove disconnect switches with new ¿key switches which are more definitive switch action. The switch indicator have been replaced with brighter more recognizable lights. Facility policy regarding stove use and the requires afety precautions has been updat reflect the need to assure power had disconnected before leaving the strunsupervised. Staff have been eding on these policy and procedure updeffective implementation of actions monitored by: The Director of Nursing will monito adherence to practices, polices and procedures and follow-up as indicator those responsible to maintain comwill be: The Director of Nursing and/or deswill complete 7 audits each week for month and then 7 audits every other for two months to include proper compliance with procedures. The	ted, i will use on ntial es: dents at risk ach eficient /¿ style in their lights nore ed ed to as been ove ucated ates. s will be r facility d/or ated. npliance ignee or one er week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING	·····	08/	06/2015	
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	added, "I do not concheck the stove at to keep it off." TMA the stove off often the residents, R72 Boss unit: On 8/4/15, at 2:46 was observed to not RD-B was observed to not locked off. NA-kitchenette At 3:20 p.m. the Enot locked off. NA-kitchenette, but left During interview or stated that the stove off. "I turned it off. can. I probably turn week. If the burner might start a fire." Dorthea unit: During tour of Dort 9:45 a.m. the stove power locked off. At 11:00 a.m. the seen powered off. Auxiliary unit: During a tour of the 8/6/15, at 10:35 a not be locked in the was in the kitchene When interviewed stated "the people"	they cook in the morning but took. I always come over and the start of my shift. We need to D verified he needed to lock because "there is a concern for likes to come into the kitchen." p.m. observed the Boss unit of have the power locked off. I do enter the area and stock to enter the area and stock t	F 323	collected will be presented to the Assurance committee by the D Nursing. The data will be reviewed/discussed at the mone Assurance Meeting. At that time Quality Assurance committee with the decision/recommendation reany necessary follow-up studies.	irector of thly Quality e the vill make egarding		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING		08/	06/2015	
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 323	is the most common Residents were ider cognitive impairme R40's MDS dated 7 severe cognitive imassistance to trans the wheelchair around R57's MDS dated 7 severe cognitive imassistance to trans the wheelchair around R59's MDS dated 7 severe cognitive imassistance to trans the wheelchair around R59's MDS dated 7 severe cognitive imassistance to trans the wheelchair around R87's MDS dated 7 severe cognitive imassistance to trans the wheelchair around R139's MDS dated 8 severe cognitive imassistance to trans the wheelchair around R139's MDS dated severe cognitive imassistance to trans the wheelchair around R283 dated 6/9/15, cognitive impairme transfer to the wheelchair around R283 dated 6/9/15, cognitive impairme transfer to the wheelchair around the unit. R310's MDS dated severe cognitive imassistance to trans	rere reviewed and the following ntified as having severe nt. 7/16/15, indicated R40 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 7/15/15, indicated R57 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 7/15/15, indicated R57 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 7/1/15, indicated R59 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 7/22/15, indicated R87 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 7/23/15, indicated R139 had pairment and required fer to the wheelchair. Once in resident was able to propel the resident was able to propel the	F 32	3			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING _		08/	06/2015	
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108	, 33		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 323	wheelchair around R225's MDS dated severe cognitive im propel self in wheel R128's MDS dated severe cognitive im assistance to trans the wheelchair around R340's MDS dated severe cognitive im assistance to trans the wheelchair around R352's MDS dated severe cognitive im propel self in wheel was able to ambula unit. R227's MDS dated severe cognitive im assistance to trans the wheelchair around R107's MDS dated severe cognitive im assistance to trans the wheelchair around R107's MDS dated severe cognitive im propel their wheelch was able to transfer self into wheelchair around R4's MDS dated severe cognitive im transfer self into wheelchair around R4's MDS dated for cognitively intact but confused, requiring was able to transfer propel wheelchair around propel wheelchair around was able to transfer propel wheelchair around was able to tran	the unit. 5/21/15, indicated R225 had pairment and was able to chair around the unit. 7/9/15, indicated R128 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 6/24/15, indicated R340 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 6/3/15, indicated R352 had pairment and was able to chair around the unit. R352 at with a walker around the with a walker around the with a walker around the unit. 5/3/15, indicated R227 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 5/20/15, indicated R107 had pairment and was able to hair around the unit, or walk on er. 6/3/15, indicated R192 had pairment and was able to heelchair and propel their the unit. 3/15, indicated R4 was at unit staff identified him as supervision if in kitchen. R4 r self into wheelchair and around the unit. R4 could walk around the unit. R4 could walk	F 32	23			
	propel wheelchair a with walker around	around the unit. R4 could walk					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245347		B. WING			08/06/2015		
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 441 4 SS=D 5	confused, requiring was able to transfer propel wheelchair a with walker around. When interviewed of director of nursing skitchen are responsiand off. This may be assistant administrates proposed in the facility; was a confused in the facility; was a confused in the facility; was able to help prevent the of disease and infection to the facility; was able to help prevent the of disease and infection to the facility; was able to help prevent the of disease and infection to the facility; was able to help prevent the of disease and infection to the facility must estimate the facility must estimate the facility; was able to help prevent the of disease and infection to the facility; was able to help prevent the of disease and infection the facility; which is the facility;	t unit staff identified him as supervision if in kitchen. R72 r self into wheelchair and round the unit. R72 could walk the unit. on 8/6/15, at 11:10 a.m. the stated "the people in the sible for turning the stove on e nursing, housekeeping, ator. Whoever was cooking is tled, A Neighborhood Guide to not Storing Food included with key during ! e/cookies and you are not be sure to check and often stored inside ey OFF STOVE when not in a CONTROL, PREVENT tablish and maintain an ogram designed to provide a omfortable environment and development and transmission ction. I Program tablish an Infection Control	F 3			9/15/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	X3) DATE SURVEY COMPLETED		
		245347	B. WING		08/06/2015	
NAME OF PROVIDER OR SUPPLIER LYNGBLOMSTEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108		30,00,2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 441	(3) Maintains a recactions related to in (b) Preventing Spre (1) When the Infect determines that a reprevent the spread isolate the resident (2) The facility must communicable dise from direct contact direct contact will treat (3) The facility must hands after each dhand washing is incorposessional practic (c) Linens Personnel must ha	or an individual resident; and ord of incidents and corrective infections. ead of Infection tion Control Program resident needs isolation to of infection, the facility must in the infection of infection infected skin lesions with residents or their food, if the ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 441			
	by: Based on observa review, the facility fappropriate hand h care for 1 of 3 resiductivities of daily live Findings include: On 8/5/15, at 8:34 was observed com R250. NA-B with gi	NT is not met as evidenced tion, interview and document failed to ensure staff utilized ygiene during the provision of dents (R250) observed during ring. a.m. nursing assistant (NA)-B pleting perineal cares with loved hands assisted R250 to and attempted to remove R20's		It is the policy of Lyngblomsten Care Center that the facility establish and maintain an infection control program designed to provide a safe, sanitary a comfortable environment and to help prevent the development and transmission of disease and infection. Lyngblomsten requires that staff wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. To assure continued complia	nd 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245347	B. WING			08/0	06/2015
NAME OF	PROVIDER OR SUPPLIER		l .	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0	70,2010
LVALORI	040TEN 04DE 0EN	T-D		14	415 ALMOND AVENUE		
LYNGBL	OMSTEN CARE CEN	IER		S	AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	soiled incontinent p NA-B removed her washing her hands the facility cell phor member. NA-B th removed her right of the hallway to look the door she put or R25's bedside to comake R250 comfor gloves and exited F On 8/5/15, at 8:43 not washed her hall leaving R25's room On 8/5/15, at 8:47 stated during interviced thand hygie before and after resonduct hand hygie before than the facility product hand hygie The facility's Hand instructed staff to p	product which R250 refused. left glove, and without or using hand sanitizer, used ne to contact another staff en went to the resident's door, glove, and opened the door to for help. When NA-B closed or clean gloves and went to over R250 with bed linens and rtable. NA-B then removed her R250's room. a.m. NA-B confirmed she had onds after glove removal or after of after glove removal, and sident contact. b. p.m. the director of nursing orotocol was for staff to ene after removal of gloves. Hygiene policy dated 5/2013, perform hand hygiene after and before and after assisting	F4	141	the following plan has been implemed Regarding cited residents: With respect to resident R250 (actors R79- evidence wrongly identified resident), she was monitored to associate negative outcomes resulted from the infection control breach. Resident currently infection free. Actions taken to identify other potent residents having similar occurrence. All residents receiving direct care a risk for infection if proper infection of practices are not maintained. To accontinued compliance, see system measures below. Measures put in place to ensure depractice does not occur: All staff have been re-educated on infection control practices with partifocus on hand washing process an sequence. Infection surveillance a tracking continue and analysis of dused to determine if staff practices contributing to the development and transmission of infection. New data analysis includes infection data croreferenced by area with specific staff determine if trending can be attributed specific staff. Effective implementation of actions monitored by: Infection Preventionist will monitor adherence to practices, polices and procedures and follow-up as indicated the infection Preventionist and/or designee will complete 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and then 5 audits each week for one month and t	ually sure no ne ntial es: re at control ssure ficient proper icular d nd ata are d a ss affing to ted to will be facility d/or ted. ppliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING			08/0	06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CENT	ER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465 SS=F	SAFE/FUNCTIONA E ENVIRON The facility must pro	L/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 4		every other week for two months to include proper compliance with procedures. The data collected will presented to the Quality Assurance committee by the Infection Prevent The data will be reviewed/discusse monthly Quality Assurance Meeting that time the Quality Assurance cor will make the decision/recommend regarding any necessary follow-up studies.	I be ionist. d at the j. At mmittee	9/15/15
	by: Based on observat review, the facility fa and appropriate ma for 6 of 18 resident R139, R223, R399, R354, R357, R385) concerns. In addition dishwashers in 4 of facility were maintal Findings include: On 8/6/15, from 1:1 environmental tour environmental servi	ion, interview and document ailed to ensure cleanliness intenance to resident rooms rooms (R79, R114, R189, R69, R178, R183, R310, reviewed for environmental n, the facility failed to ensure 8 kitchenettes throughout the ned in a sanitary manner. 1 p.m. to 1:52 p.m. an was conducted. The ces director (ESD) and a staff cal plant (PP) were present			It is the policy of Lyngblomsten Ca Center that the facility provide a sa functional, sanitary, and comfortable environment for residents, staff, an public. To assure continued complitive following plan has been implem Regarding cited residents: With respect to resident the 6 residented for cleanliness and maintenar areas of concern related to peeling chipped paint, scuff marks, soiled and damaged sheetrock have been repaired and/or cleaned. With respect the 8 residents cited for dust covere bathroom vents, all vents have been removed, thoroughly cleaned and	fe, le d the ance nented. lents nce, all and/or carpet, n pect to ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING			08/0	06/2015
NAME OF I	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	00/0	30/2010
LVNCDI	OMOTEN CADE CEN	TED		14	15 ALMOND AVENUE		
LYNGBL	OMSTEN CARE CEN	IER		S	AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	during the tour. Duenvironmental conconfirmed with the R79's bathroom was up approximately and peeling paint reverified the chipper uncleanable surface. R114's bathroom was floor up approximately one area the doorjamb paint area created PP staff member repreviously covering fallen off. R189's room had be over approximately room. The bathroom approximately one paint. The ESD verae were not a county for the est of the resident's redocumentation of steep the side of the right side of the right side of the right side of the	ring the tour the following cerns were identified and ESD and PP staff member: all had an area from the floor one foot, which had chipped lear the doorjamb. The ESD dipaint area created an ite. vall also had an area from the tely one foot which was a paint was peeling and sticky. The ESD verified the chipped an uncleanable surface. The eported that a plastic guard of the chipped paint must have a plack scuff marks on the floor of five feet on the left side of the middle door and peeling rified that the chipped and peeling rified that the chipped paint leanable surface and that the not homelike. It is soiled build up on the carpet and had a dirty appearance, that the facility was aware of the twould not allow staff to lings to clean the floor. Review cord revealed no such refusals.	F 4	65	replaced. All kitchenette refrigerate freezers, and cabinet doors and draftonts have been cleaned. Kitchene floors, including baseboards have be contracted to be cleaned and are scheduled to be completed by 9-31 Dishwashers on Dorothea, Koller, a Fergstad neighborhoods have been de-limed. Actions taken to identify other potent residents having similar occurrence Environmental audits have been completed for all areas of the building note any areas of concern related to cleanliness, maintenance, and funct the facility environment. All areas a equipment noted needing attention identified and plans developed for the requirement to maintain a safe, functions and completed to that requirement to the appropriate responsible party. Phy Plant and Environmental Services have deviced and enhanced existing maintenance and cleaning schedule assure items/areas needing service are addressed on a schedule. Facility staff identified need (work orders) have been digitized a for improved tracking and monitoring an	awer ette been -15. and notial es: open of and were imely ficient ctional, ent and rn sical nave es to e/repair ellity ds llowing ag.	
		observed by the bathroom e floor up about one foot. The			Effective implementation of actions monitored by:	will be	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245347	B. WING		08/	06/2015	
	PROVIDER OR SUPPLIER OMSTEN CARE CEN			STREET ADDRESS, CITY, STATE, ZIP COL 1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 465	ESD verified that the uncleanable surface should be cleaned. R399's room had a exposed approximate wall behind the also an area on the approximately one was missing paint, scuff marks. The Ester rock areas of and that the scuff in During the tour, the there had been a vice repairs, but was now work orders. Additionally during bathroom (R69, R18357, R385) vents with a heavy layer. The PP staff membyear their departminent of the preventation system confirm whether the completed yet this on 8/6/15, at 1:53 member reported to preventative maint. They stated their phousekeeper to fill paint/maintenance. ESD. The ESD fur difficult for the staff.	the chipped paint areas created be and that the scuff marks up. an area where sheet rock was ately two feet in diameter on a resident's recliner. There was a left side of the room foot up the wall where there and there were wheel chair and werks should be cleaned up. The PP staff member reported work order submitted for the part able to supply a copy of the stable to s	F 46	Administrator will monitor faci adherence to practices, police procedures and follow-up as i Those responsible to maintain will be: The Administrator and/or desi complete 3 audits each week month and then 3 audits every for two months to include proceompliance with procedures. collected will be presented to Assurance committee by the Administrator. The data will be reviewed/discussed at the motopolar Assurance Meeting. At that tir Quality Assurance committee the decision/recommendation any necessary follow-up studies.	es and/or ndicated. n compliance gnee will for one y other week per The data the Quality the Quality the will make a regarding		

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245347	B. WING		08.	/06/2015	
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 465	Order Procedure da orders would be pic Friday at 8:00 a.m. orders not presently kept on the clip boa office which would assigned to complet On 8/6/15, at 9:23 a kitchenettes was condicted itian (RD)-B and identified: Refrigeral splattered on shelv seals had brown ye doors and drawer frup grime. Floors has the baseboards. RI kitchenettes were resulted in the process of the dishurch order to have heaven outside of the dishurch of the dishurch of the dishurch order to have heaven outside of the dishurch of the dishur	enance Department Work ated 4/1985, indicated work cked up Monday through and 1:00 p.m. and work y being performed, would be ards outside the maintenance allow others not specifically ete the work orders. a.m. a tour of the facility's enducted with registered at the following issues were ators had dried on food es and inner doors. Freezer ellow build up in them. Cabinet ronts had sticky areas of built ad brown to black build up at D-B verified findings	F 4	65			

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 08/06/2015 245347 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1415 ALMOND AVENUE LYNGBLOMSTEN CARE CENTER SAINT PAUL, MN 55108 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lyngblomsten Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. **EPOC** PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL. MN 55101-5145

Electronically Signed

TITLE

08/31/2015

(X6) DATE

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

Facility ID: 00501

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

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		E CONSTRUCTION 01 - MAIN BUILDING 01	COMPLETED		
		245347	B. WING			08/0	06/2015	
	PROVIDER OR SUPPLIER	rer		1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE AINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 000	00 Continued From page 1		ΚO	000				
	Or by email to: Marian.Whitney@s Angela.Kappenmar							
		RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION:						
	1. A description of what has been, or will be, done to correct the deficiency.							
	2. The actual, or pro	oposed, completion date.						
		title of the person ection and monitoring to nce of the deficiency.						
	Lyngblomsten Care Center is a 4-story building with a full basement. The building was constructed at 2 different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1976, an addition was constructed to the South side that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building.							
	has a fire alarm sys the corridors, space monitored for auton notification. All resid single station smoke	fire sprinklered. The facility tem with smoke detection in es open to the corridors that is natic fire department dent rooms are equipped with e detection. The facility has a s and had a census of 225 at ey.						

Facility ID: 00501

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245347	B. WING	i		08/	06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER	·	1	STREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000 K 018 SS=D				000 018			9/15/15
	required enclosures hazardous areas as those constructed of wood, or capable of minutes. Doors in required to resist the no impediment to the are provided with a the door closed. D	s of vertical openings, exits, or re substantial doors, such as of 1¾ inch solid-bonded core f resisting fire for at least 20 sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors means suitable for keeping utch doors meeting 19.3.6.3.6.3					
	Roller latches are p in all health care fa	orohibited by CMS regulations cilities.					
	Based on observat did not have a corri requirements of NF 19.3.6.3.2. This def safety of the reside compartment. Findings include: On facility tour betw	s not met as evidenced by: tion and interview, the facility dor door that meets the PA 101 LSC (00) Section ficient practice could affect the ents within the smoke ween 09:00 AM and 02:00 PM as observed that the corridor			K018 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 101 LSC Section 19.3.6.3.2, the doors to the floor east dining room have been scheduled for replacement. Doors been ordered and are due to arrive replaced no later than 9-29-15. Door replacement installation will be perfeby licensed contracted agency. Physical part of the property of the property of the perfect of th	(00) 3rd have and be or ormed	

1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245347	B. WING	·		08/	06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE AINT PAUL, MN 55108		
 (X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 018 K 029 SS=E			TOTAL AND TRANSPORTATION AND TRA	018	Plant Director will be responsible to oversee and assure the successful completion of the door replacement. Physical Plant Director will test, at least monthly, all fire doors for appropriate closure and latch.		9/15/15
	Based on observate failed to provide produce accordance with the -2000 edition, Section Findings include: On facility tour betwon 08/06/2015, it was penetrations in the did not latch in the factor of latch when tester the section of latch when tester according to the provide p	y Room door to corridor did			K029 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 101-2000 edition, Section 19.3.2.1 and 8.4.1, following actions have been taken: 1. The 1st floor laundry room door adjusted on 8-6-15 for proper closu latch. 2. The 3rd floor janitor room A-324 penetration area on wall around cor has been appropriately filled with a rated caulk on 8-27-15 3. The 3rd floor janitor room adjact room A350 opening between soiled	the r was re and 4 nduit fire	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245347	B. WING			08/	06/2015
	PROVIDER OR SUPPLIER	TER	STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 029 K 033 SS=E	in the corridor wall a 3) 3rd floor janitor across from room A pipe. 4) Lower level TV self close and latch 5) Lower level Red not self close and la This deficient pract staff (CA), at the tin NFPA 101 LIFE SA Exit components (senclosed with consresistance rating of arranged to provide	around conduit. room to Soiled Utility room A-350 had a 4" hole around storage room doors did not when tested. I Bag storage room doors did atch when tested. ice was verified by the facility ne of discovery. FETY CODE STANDARD uch as stairways) are truction having a fire at least one hour, are a continuous path of escape, ion against fire or smoke from	KO		room is to be appropriately filled 15. Facility staff are completing repair. 4. The lower level television storage and appropriated devices installed on 8-24-15 and self-close and latch appropriately. 5. The lower level red bag storage had appropriate closure device had appropriate closure device had appropriately. Physical Plant Director will overse completion of all work required a perform routine audits of related and equipment function.	rage closure now dege room vices f-close ee the nd will	9/15/15
	Based on observation failed to provide and protection required Sections 19.3.1.1, could affect all 76 refindings include: On facility tour between	s not met as evidenced by: ion and interview, the facility d maintain the vertical opening by NFPA 101 - 2000 edition, 8.2.5 .This deficient practice esidents. veen 09:00 AM and 02:00 PM as observed that 3C stairwell			K033 To meet the requirement of 42CF Subpart 483.70(a), NFPA 101-20 Sections 19.3.1.1, 8.2.5, all wall benetrations in 3C stairwell will b appropriately filled with a fire rate caulking on 9-4-15. The Physica Director will observe and maintal benetrations per appropriate cod	0 edition, e ed sealing Il Plant n all wall	

	(O) O : () () ()	T CHILDION ID CE. (17020	1		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		(X3) DATE SURVEY COMPLETED	
		245347	B. WING		08/06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	•	had a penetration around	K 03:	3 standards.	
K 038 SS=D	staff (CA), at the tir NFPA 101 LIFE SA Exit access is arrar	ice was verified by the facility me of discovery. FETY CODE STANDARD nged so that exits are readily nes in accordance with section	K 03	3	9/15/15
	Based on observa- has failed to provid. This deficient pract rapid evacuation of in the event of an e	s not met as evidenced by: tion and interview, the facility e a proper exit to the outside. ice could affect the safe and all residents, visitors and staff mergency that may require accordance with section 7.1.		K038 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA Section 7.1, 19.2.1, the 1st floor C exit door has bee adjusted to open easily, adjustments completed on 8-6-15. The Physical Pla Director will inspect all exit doors month for proper operation.	nt
	on 08/06/2015, it w exit door to the outs	veen 09:00 AM and 02:00 PM as observed that the1st floor C side was difficult to open and os to jar the door open.			
K 062	staff (CA), at the tin	ice was verified by the facility ne of discovery. FETY CODE STANDARD	K 06	2	9/15/15
SS=D	continuously mainta condition and are in	c sprinkler systems are ained in reliable operating aspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,	OMASSIE OMASSIE		

PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245347	B. WING		08/0	06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	rer		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	Continued From pa 9.7.5	ge 6	K 062	2		
	Based on observation complete automatic being maintained in 25(99) Section 9.2. effect all occupants were to fail under findings include: On facility tour betwon 08/06/2015, it was prinkler wrench in facility.	veen 09:00 AM and 02:00 PM as observed that there was no the spare head box on in the ce was verified by the facility		K062 To meet the requirement of 42CFF Subpart 483.70(a), NFPA 25(99) S 9.2.7, the sprinkler wrench has befordered and will be replaced in the head box by 9-15-15. The Physica Director will observe periodically to the wrench is available in the spare box.	ection en spare al Plant assure	
	•					

Event ID:TJUU21



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered August 21, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5347028

Dear Mr. Heinecke:

The above facility was surveyed on August 3, 2015 through August 6, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Lyngblomsten Care Center August 21, 2015 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gloria Derfus at (651) 201-37925 or email: gloria.derfus@state.mn.us.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00504	B. WING		08/06/2015	
		00501			08/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S I OND AVENU	STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TFR .	UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.					
	that may result fron orders provided tha the Department wit	hearing on any assessments non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/31/15

TITLE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00501		B. WING		08/0	6/2015
LYNGBLOMSTEN CARE CENTER 1415 ALM			ORESS, CITY, S OND AVENU UL, MN 551			
(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 SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically. is necessary for State enter the word "correct. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the	2 000	The assigned tag number appears far left column entitled "ID Prefix of The state statute/rule out of complisted in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state is after the statement, "This Rule is reas evidence by." Following the surfindings are the Suggested Method Correction and Time period for Complete Disregard The Fourth Column which States, "Provider's Plan of Correction." This applies of Federal Deficiencies only. Will appear on Each Page. There is no requirement to Submit a Plan of Correction of Minnesota Statutes/Rules.	Fag." iance is of the "To order. ings statute not met veyors d of rrection. DING OF THIS	
2 530	Subp. 4. Decision to decision to apply a comprehensive res restrictive restraint incorporated into the The comprehensive progressive removaless restrictive mea obtain an informed in a physical or che order must be obtain	O Subp. 4 Use of Restraints o apply restraint. The restraint must be based on the ident assessment. The least must be used and e comprehensive plan of care. e plan of care must allow for all or the progressive use of ns. A nursing home must consent for a resident placed mical restraint. A physician's ned for a physical or chemical cifies the duration and	2 530			9/15/15

Minnesota Department of Health

STATE FORM 6899 TJUU11 If continuation sheet 2 of 27

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00501	B. WING		08/0	6/2015
	PROVIDER OR SUPPLIER	TER 1415 ALM	DRESS, CITY, S OND AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 530	circumstances undused, including the in this part requires during the resident's trictly for the purport. This MN Requirements by: Based on observation review, the facility for restraint, the use of used as a swim devinches in diameter resident's bed matt to prevent the resident's bed matters. During an observation of the switch cut on addition it was note noodles laying under mattress on the bed causing it to tip tow noodles were noted 8/4/15, at 2:22 p.m. laying in bed, leaning side. Her phone (or right side of the bed due to the position to be unable to ans staff to assist her.	ge 2 er which the restraint is to be monitoring interval. Nothing a resident to be awakened is normal sleeping hours ose of releasing restraints. ent is not met as evidenced on, interview and document alled to assess as potential is swim noodles (commonly vices, approximately 2.5 is 5 feet long) to bolster a ress toward the wall, in order ent from getting out of bed for still reviewed for accidents. o.m. registered nurse (RN)-Fable to get out of bed by ion and interview with R61 in at 8:10 a.m. A perimeter ut was observed on the bed. In different the right side of the different resident in the overbed table next to the different place again on when R61 was observed ing toward the wall on the left in the overbed table next to the different result. The surveyor alerted in the swim noodles a.m. the swim noodles	2 530	Corrected		

Minnesota Department of Health

STATE FORM 6899 TJUU11 If continuation sheet 3 of 27

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMPI	
	00501	B. WING		08/0	6/2015
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	1415 AI M				
LYNGBLOMSTEN CARE CENTER SAINT P.			08		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
Continued From pa	ge 3	2 530			
•					
remained under the	mattress on the bed.				
mattress was tipped by placement of the mattress. The bed addition one of the	d to the left (wall side of room) swim noodle under the was against the wall. In noodles had been moved up				
been admitted to th fall that had resulted fractures. Additiona	e facility on 4/23/15, after a d in right hip and right wrist I admission diagnoses include				
assessment in prog R61 had a Brief Inte (BIMS) (cognition a which indicated R6- dysfunction. In addi had significant depr trouble concentratir feeling down and de resident had indicat An MDS dated 4/29 the call light, was at extensive assist and two for bed mobility indicated restraint u The Care Plan date should engage in si avoid overly deman should be use of co plan also indicated usual and had a po- concentrating, movi	press dated 7/29/15, indicated erview for Mental Status ssessment) score of 3/15, 1 had severe cognitive tion, the MDS identified R61 ression due to insomnia, 10g, moving or speaking slowly, 15g, indicated R61 could use thigh risk of fall, and required divelopments with the red she'd be better off dead. 16/15, indicated R61 could use thigh risk of fall, and required divelopments with the red she'd bearing support of and toilet use. Neither MDS use for R61. 16/16/16/16/16/16/16/16/16/16/16/16/16/1				
	PROVIDER OR SUPPLIER OMSTEN CARE CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa remained under the On 8/6/15, at 8:13 a mattress was tipped by placement of the mattress. The bed addition one of the under R61's torso a side. The face sheet in th been admitted to th fall that had resulted fractures. Additional senile dementia, and A significant change assessment in prog R61 had a Brief Inte (BIMS) (cognition a which indicated R6- dysfunction. In addi had significant depr trouble concentrating feeling down and de resident had indicate An MDS dated 4/29 the call light, was at extensive assist and two for bed mobility indicated restraint to The Care Plan date should engage in si avoid overly deman should be use of co plan also indicated usual and had a po- concentrating, movi speaking. The care	OSO1 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 remained under the mattress on the bed. On 8/6/15, at 8:13 a.m. R61 was in bed and the mattress was tipped to the left (wall side of room) by placement of the swim noodle under the mattress. The bed was against the wall. In addition one of the noodles had been moved up under R61's torso area to prop her over on her side. The face sheet in the record indicated R61 had been admitted to the facility on 4/23/15, after a fall that had resulted in right hip and right wrist fractures. Additional admission diagnoses include senile dementia, anxiety, and insomnia. A significant change Minimum Data Set (MDS) assessment in progress dated 7/29/15, indicated R61 had a Brief Interview for Mental Status (BIMS) (cognition assessment) score of 3/15, which indicated R61 had severe cognitive dysfunction. In addition, the MDS identified R61 had significant depression due to insomnia, trouble concentrating, moving or speaking slowly, feeling down and depressed, and that the resident had indicated she'd be better off dead. An MDS dated 4/29/15, indicated R61 could use the call light, was at high risk of fall, and required extensive assist and weight bearing support of two for bed mobility and toilet use. Neither MDS indicated restraint use for R61. The Care Plan dated 4/28/15, indicated staff should engage in simple structured activities and avoid overly demanding tasks, and that there should be use of consistent care givers. The care plan also indicated R61 was sleeping more than usual and had a poor appetite, trouble concentrating, moving and was slow with speaking. The care plan identified R61 as being	OMSTEN CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 remained under the mattress on the bed. On 8/6/15, at 8:13 a.m. R61 was in bed and the mattress was tipped to the left (wall side of room) by placement of the swim noodle under the mattress. The bed was against the wall. In addition one of the noodles had been moved up under R61's torso area to prop her over on her side. The face sheet in the record indicated R61 had been admitted to the facility on 4/23/15, after a fall that had resulted in right hip and right wrist fractures. Additional admission diagnoses include senile dementia, anxiety, and insomnia. A significant change Minimum Data Set (MDS) assessment in progress dated 7/29/15, indicated R61 had a Brief Interview for Mental Status (BIMS) (cognition assessment) score of 3/15, which indicated R61 had severe cognitive dysfunction. In addition, the MDS identified R61 had significant depression due to insomnia, trouble concentrating, moving or speaking slowly, feeling down and depressed, and that the resident had indicated she'd be better off dead. An MDS dated 4/29/15, indicated R61 could use the call light, was at high risk of fall, and required extensive assist and weight bearing support of two for bed mobility and toilet use. Neither MDS indicated restraint use for R61. The Care Plan dated 4/28/15, indicated staff should engage in simple structured activities and avoid overly demanding tasks, and that there should be use of consistent care givers. The care plan also indicated R61 was sleeping more than usual and had a poor appetite, trouble concentrating, moving and was slow with	OF CORRECTION DENTIFICATION NUMBER: A BUILDING:	OF CORRECTION DENTIFICATION NUMBER: DOS01 B. WING B. WING DENTIFICATION NUMBER: A BUILDING: B. WING DENTIFICATION NUMBER: A BUILDING: B. WING DENTIFICATION NUMBER: STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108 SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MIST BE PRECEDED BY PLIL.] REGULATORY OR ISC DENTIFYING INFORMATION.] Continued From page 3 Continued From page 4 Continued From page 5 Continued From page 4 Continued From page 5 Continued

Minnesota Department of Health

STATE FORM TJUU11 If continuation sheet 4 of 27

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108 D	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
LYNOBLOMSTEN CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX PREFIX TAG PREFIX PREFIX TAG PREFIX PREF			00501	B. WING		08/0	6/2015
CALL DEPTICION DEPTICION CALL DEPTICION DEPTICION CALL DEPTICION DEPTICION DEPTICION DEPTICION DEPTICION DEPTICION DEP	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 530 Continued From page 4 right hip and wrist fracture putting R61 at risk for falls. An intervention included the use of a low bed. A handwritten and undated note added to the fall care plan stated a silent alarm pad was in place on the bed to alert staff of the resident's movements, and indicated "Noodle under the out jsic] edge of bed to prevent falls." A Fall Report dated 5/11/15, indicated R61 had stood and walked over to shut off the light in her room and that she'd stated, "when I came back, then's when I fellwas unable to get back into bed." The report indicated R61 had denied hitting her head and no bruise or injury was noted, R61 had also denied pain, but appeared confused. At the time, the staff interventions included re-orienting R61 on how to use call light, Tab (electronic) alarm to call light system (under upper back), low bed. The facility was unable to verify when the swim noodles had been placed under R61's mattress "to prevent falls." A review of nursing progress notes indicated the resident had been found to sit on the edge of her bed on 5/10/15 at 4:37 p.m. On 5/11/15, the reisdent had been found to sit on the edge of her bed. On 5/13/15, at 4:19 a.m. R 61 had also been found sitting on the edge of her bed. And again on 6/17/15 at 6:16	I YNGBI OMSTEN CARE CENTER			· -			
right hip and wrist fracture putting R61 at risk for falls. An intervention included the use of a low bed. A handwritten and undated note added to the fall care plan stated a silent alarm pad was in place on the bed to alert staff of the resident's movements, and indicated "Noodle under the out [sic] edge of bed to prevent falls." A Fall Report dated 5/11/15, indicated R61 had stood and walked over to shut off the light in her room and that she'd stated, "when I came back, then's when I fellwas unable to get back into bed." The report indicated R61 had denied hitting her head and no bruise or injury was noted, R61 had also denied pain, but appeared confused. At the time, the staff interventions inlcuded re-orienting R61 on how to use call light, Tab (electronic) alarm to call light system (under upper back), low bed. The facility was unable to verify when the swim noodles had been placed under R61's mattress "to prevent falls." A review of nursing progress notes indicated the resident had been found to sit on the edge of her bed on 5/10/15 at 4:37 p.m. On 5/11/15, the reisdent had fallen. Mobility aides at that time had been identified as walker, trapeze, and mobility bars on the bed. On 5/13/15, at 4:19 a.m. R 61 had also been found sitting on the edge of her bed of her bed. And again on 6/17/15 at 6:16	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
a.m., R61 had been found sitting up on the bed, and R61 had pulled out her Foley catheter stating, "it was bothering me." The nursing progress notes review did not identify when the use of the swim noodles had been initiated.	2 530	right hip and wrist fifalls. An intervention bed. A handwritten the fall care plan staplace on the bed to movements, and in [sic] edge of bed to A Fall Report dated stood and walked or room and that she'd then's when I fellv bed." The report in her head and no brhad also denied parthe time, the staff ir re-orienting R61 on (electronic) alarm to upper back), low bed. The facility was una noodles had been provided the bed on 5/10/15 at 4 reisdent had fallen. had been identified mobility bars on the a.m. R 61 had also edge of her bed. Ar a.m., R61 had beer and R61 had pulled stating, "it was both. The nursing progre when the use of the stating progression progr	racture putting R61 at risk for on included the use of a low and undated note added to ated a silent alarm pad was in alert staff of the resident's dicated "Noodle under the out prevent falls." 5/11/15, indicated R61 had ver to shut off the light in her d stated, "when I came back, was unable to get back into dicated R61 had denied hitting uise or injury was noted, R61 in, but appeared confused. At atterventions inlcuded how to use call light, Tab o call light system (under ed.) able to verify when the swim placed under R61's mattress progress notes indicated the ound to sit on the edge of her :37 p.m. On 5/11/15, the Mobility aides at that time as walker, trapeze, and bed. On 5/13/15, at 4:19 been found sitting up on the bed, I out her Foley catheter tering me."	2 530			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00501	B. WING		08/0	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TER	IOND AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 530	Continued From pa	ige 5	2 530			
	The chart lacked id and lacked docume the swim noodles a were placed under from getting out of On 8/4/15, at 2:25 pnoodles had been pto give it a lift so shhad been found clir times. RN-F stated for a restraint, since swim noodle use as out of bed. It [swim intervention; the lip continues to get our reviewed the chart "I cannot find when swim noodles to ho intervention found (R61) got up and wand fell trying to ge	entification of when initiated, entation of any assessment of is potential restraints which the mattress to prevent R61				
	(DON) stated she, the lipped mattress recommendations further stated, "that think they feel it is a lipped mattress." That if a bed was pustrong side of a resthat could be a form	o.m. the director of nursing "doubted the manufacturer of or the bed would make for swim noodles." The DON intervention pre-dates me, I a small little addition to the he DON also acknowledged at up against the wall on the hident who has hemiparesis, no frestraint, but added "If still able to get out of bed. I at."				
		a.m., trained medication aide The swim noodles, are used to				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00501	B. WING		08/0	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TFR	OND AVENUUL, MN 551			
(X4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
2 530	Continued From pa	ige 6	2 530			
2 530	keep her from going putting her legs over that. I think it's a nubed, once you put the equipment." When use the swim nood nursing assistant canot here". On 8/6/15, at 11:09 noodles are a fall in box intervention, doing ago. We have noodles are not to help remind the rest there." RN-G verification with a lipped of they (residents) contributed in the individual, and they intention was to creat in the second of the individual of	g over the edge of the bed, by er. I don't know who decides arse order. It just stays on the hem on. It's just part of the asked how she would know to les, TMA-B reviewed the are sheets and stated, "oh it's a.m., RN-G stated "the atervention, it's an out of the eveloped in a fall conference, used them for a long time, restrict movement, it's just to sident the edge of the bed is ed the noodles could be used mattress, "It's just because a tinue to swing (legs) out of a surveyor asked RN-G how he whether the swim noodle a resident without assessing, as a good question." I.m., the administrator and wed. The DON stated the eate a sense of perimeter for the noodle had been effective as DON said, "A restraint would ement, would limit access to n't view it (the noodle) as a the DON also stated, "It's kind ent that you don't know if it's a transcess it." D.m. the DON provided the appropriate use of the ided: hydrotherapy, aquatic es. "For aquatic exercise"				

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IVIInneso	<u>ta Department of He</u>	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00501	B. WING		08/06/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LYNGRLOMSTEN CARE CENTER		IOND AVENU UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
2 530	Continued From pa	ge 7	2 530			
	use of any restraint 2. To protect reside 1.) Data collect following: a. Medical diag b. Physical a c. Cognitive d. Eliminatic e. Decision f. Behavior 2.) Docume restraints 3. Review of falls for and activity involved 4. Obtain physician type, reason for use	nt's rights Procedure: ion and analysis of the nosis present Assessment status on pattern making skills pattern ntation of alternatives to or times, place of occurrence d. order for medical diagnosis, e, when to be used, utes and release every two change. and approaches nours sheet.				
	director of nursing (develop, review, an procedures to ensuidentified, comprehiplanned to ensure trestraints. The DON all appropriate staff procedures. The DO monitoring systems compliance.	ON or designee could develop to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE COMP	LETED
	00501	B. WING		08/0	6/2015
ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
I YNGBI OMSTEN CARE CENTER					
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 SHOUL)	D BE	(X5) COMPLETE DATE
Continued From page	ge 8	2 545			
Resident Assessme Subp. 3. Frequence	ent; Frequency y. Comprehensive resident	2 545			9/15/15
A. within 14 day B. within 14 day the resident's physic	s after the date of admission; s after a significant change in cal or mental condition; and				
by: Based on observation review, the facility facomprehensive ass for 1 of 3 residents identified oral health facility failed to company significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the signified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the signified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the signified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the significant change at (R178) who was identified on the signified on the significant change at (R178) who was identified on the signified on the signified	on, interview and document ailed to complete essment of oral/dental status (R244) reviewed with a concerns. In addition, the plete comprehensive assessment for 1 of 1 resident entified as having an		Corrected		
missing several teer jaws when he laugh asked if he had any did not respond, but On 8/5/15, at 7:24 a seated on his whee -At 7:34 a.m. when he was doing R244 eyes closed. When	th to both the upper and lower ed after making a joke. When problems with chewing R244 i just smiled at the surveyor. I.m. R244 was observed Ichair in the day room. approached and asked how stated "good" and kept his asked if he was still tired he				
	ROVIDER OR SUPPLIER SUMMARY STA' (EACH DEFICIENCY REGULATORY OR LS) Continued From page MN Rule 4658.0400 Resident Assessments must A. within 14 days B. within 14 days B. within 14 days the resident's physic C. at least once This MN Requirements by: Based on observation of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive ass for 1 of 3 residents identified oral health facility failed to comprehensive	ODSO1 ROVIDER OR SUPPLIER DMSTEN CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete comprehensive assessment of oral/dental status for 1 of 3 residents (R244) reviewed with identified oral health concerns. In addition, the facility failed to complete comprehensive significant change assessment for 1 of 1 resident (R178) who was identified as having an improvement in activities of daily living (ADLs). Findings include:	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, S DMSTEN CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete comprehensive assessment for 1 of 3 residents (R244) reviewed with identified oral health concerns. In addition, the facility failed to complete comprehensive significant change assessment for 1 of 1 resident (R178) who was identified as having an improvement in activities of daily living (ADLs). Findings include: Dental: R244 was observed on 8/3/15, at 4:00 p.m. to be missing several teeth to both the upper and lower jaws when he laughed after making a joke. When asked if he had any problems with chewing R244 did not respond, but just smiled at the surveyor. On 8/5/15, at 7:24 a.m. R244 was observed seated on his wheelchair in the day room. -At 7:34 a.m. when approached and asked how he was doing R244 stated "good" and kept his eyes closed. When asked if he was still tired he stated "no" then opened his eyes and looked at	PROVIDER OR SUPPLIER ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 2 545 MN Rule 4658,0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete comprehensive assessment for 1 of 3 residents (R244) reviewed with identified oral health concerns. In addition, the facility failed to complete comprehensive significant change assessment for 1 of 1 resident (R178) who was identified as having an improvement in activities of daily living (ADLs). Findings include: Dental: R244 was observed on 8/3/15, at 4:00 p.m. to be missing several teeth to both the upper and lower jaws when he laughed after making a joke. When asked if he had any problems with chewing R244 did not respond, but just smiled at the surveyor. On 8/5/15, at 7:24 a.m. R244 was observed seated on his whelchair in the day room. A BUILDING: B. WIND 510B PRECEX TABLE PROVIDERS LIP OF CORRECTIVE (EACH OCRORS-PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERINCE DTO NOT CROSS-REFERINC	DISTRICTION DISTRICTION NUMBER: 00501 B. WING B. WING B. WING COMPONIES OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1415 ALMOND AVENUE SAINT PAUL, MN 55108 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY PLUI, MN 55108) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY PLUI, MN 55108) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY PLUI MN 55108) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY PLUI MN 55108) PROVIDERS PLAN OF CORRECTION ACIDN BEACH CORRECTIVE ACTION SHOULD BE PREFIX FROM TAGE CONTINUED TO THE PRESENCE OF THE PREFIX BEACH CORRECTIVE ACTION SHOULD BE PREFIXED TO BE PROVIDED BEACH CORRECTIVE ACTION SHOULD BE PREFIXED TO BEACH CORRECTIVE ACTION SHOULD BE PREFIXED TO BE PREFIXE

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00501	B. WING		08/0	06/2015
LYNGBLOMSTEN CARE CENTER 1415 ALM		DDRESS, CITY, S MOND AVENU NUL, MN 551(
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 545	to be missing teeth teeth appeared yell lower jaw appeared - At 8:35 a.m. to 9:0 eat his breakfast ar long time chewing he chew the bacon appropriate between escrambled eggs us chin and lip muscle and asked how the good but indicated two stripes of bacor R244 was not obsessymptoms of pain or drinking. R244's Oral Assessindicated he did not however, the Oral/I the significant chand dated 4/1/15, indicated the severely impaired of extensive physical abrushing teeth. The (CAA) dated 4/3/15 dental/oral health scomprehensively as On 8/5/15, at 10:33 who also was the Megistered dietician L-Oral/Dental Statuthere was a tool RI visual assessment stated she was goir phone RN-A was over eviewed the significant of the significant chands as the significant chands are successful to the significant chands are successf	to the right lower jaw and ow and the front tooth on the	2 545			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00501	B. WING			08/06/2015	
					1 00/0	30,2010	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S				
LYNGBL	LYNGBLOMSTEN CARE CENTER 1415 AL						
	T		AUL, MN 5510			1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO! CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
2 545	Continued From pa	ge 10	2 545				
	indicated she looked assessment from with the facility and that the assessment. - At 10:42 a.m. RD-MDS based on the if anything came up dental status it wou staff. RD-A acknow MDS based on the 7/6/15, which had in problems yet he had further stated she cassessment and with R244 had any broken the Add any broken the Add any broken the Add and the Add a	got off the phone RD-A had ad at the nursing oral when resident was admitted to was how she had completed. A stated she completed the nursing oral assessment and or in regards to a change in all the communicated to her by dedged she had completed the Oral Assessment dated andicated R244 had no teeth did several missing teeth. RD-A did not do an actual oral could not be able to know if en or missing teeth. A stated she would have to be accurate and to have to be accurate and to have that concerns R244 had if any. I'l sign off on the MDS's and I implete various sections it's an ort."					
	stated she usually a cares in the mornin teeth. NA-A indicate R244's teeth he wo she had to assist hi the upper and lowe from her recollection always some mission not sure where and - At 12:04 p.m. the stated "we have to have to continue to for residents like himake adjustments" assessment had be	a.m. nursing assistant (NA)-A assisted R244 with all of his g which included brushing his ed when it came to brushing uld attempt to brush them but im more in order to get both r jaws. NA-A further stated in she had noted R244 had ng teeth in his mouth but was how many. director of nursing (DON) do an assessment and we attempt to do assessments m who refuse and have to DON acknowledged the oral een missed in the beginning ity was working on getting all					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00501	B. WING		08/0	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	IFR	MOND AVENU AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 545	the assessments to electronic health re friendly to monitor a further stated he we to be accurate and getting or having a all the oral assessments. "Routine dental inspection of the ordiagnosis of dental as needed, dental cindicate who in the completing the oral ensured that was c	o Point Click Care (PCC- cord) which would be more all the assessments. DON ould have expected the MDS the facility was looking into dental hygienist come in to do	2 545			
	dining room. R178 breakfast table and other side of the dir walker. His stature and the gait was structure dining without staff. The admission MD R178's cognitive so impairment). The Mextensive assistance in and out of room, Supervision and see identified as having range of motion for The quarterly MDS	S dated 9/12/14, indicated core was 9 (moderate cognitive MDS identified R178 required ce of one staff member to walk locomotion on and off the unit; tup with eating. R178 was no impairment in functional				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00501	B. WING	B. WING		08/06/2015	
NAME OF	PROVIDER OR SUPPLIER		INDESS CITY S	TATE ZID CODE	1 00/0	072010	
NAME OF	PROVIDER OR SUPPLIER		IOND AVENU	STATE, ZIP CODE			
LYNGBL	I YNGRI OMSTEN CARE CENTER		UL, MN 551				
(X4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION .	(X5)	
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETE DATE	
2 545	Continued From pa	ge 12	2 545				
	and out of room, locimproved to indepe staff, and eating ha after set up. R178 vimpairment in funct arm. The medical resignificant change limprovements R17 and on the unit, eat On 8/5/15, at 2:55 padmission and quadocumentation for cliving and acknowles Significant Change she had viewed all and with current cochanges. Agreed the on the MDS but pra RN-A verified the cli	o.m. RN-A reviewed R178's rterly MDS's and supporting cognition and activities of daily edged R178 should have had a MDS completed. RN-A stated locomotion as one change, gnition score now he had two nat it was four different areas actically looked at as one. inical record lacked evidence ge in status was considered					
	Resident Assessme version 3.0 dated la "A 'significant chang improvement in a renot normally resolve staff or by impleme clinical intervention declines only); 2. In the resident's health interdisciplinary reviplan." In addition, a significompleted for improdument in two	ang Term Care Facility ent Instrument User's Manual ast revised on October 2014, ge' is a decline or esident's status that: 1. Will e itself without intervention by nting standard disease-related s, is not 'self-limiting' (for apacts more than one area of a status; and 3. Requires iew and/or revision of the care cant change should be evement as followed: o or more of the following: nt in an ADL physical					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00501	B. WING		08/06/2015		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/0	0/2015	
		1415 AI M	OND AVENU				
LYNGBL	OMSTEN CARE CEN	SAINT PA	UL, MN 551	08			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 545	Continued From pa	ge 13	2 545				
	as Independent, Suassistance since later Decrease in the name Behavioral symptor and/or the frequence - Resident's decision better; - Resident's incontibuter; - Overall improvem SUGGESTED MET The administrator of dietitian has time to resident assessment in condition occurs. Educate the staff regretated to comprehed irector of nursing of resident records to assessments are of significant change. The quarterly quality	pere a resident is newly coded apervision, or Limited st assessment; umber of areas where ms are coded as being present by of a symptom decreases; on making changes for the mence pattern changes for the mence pattern changes for the ent of resident's condition." THOD OF CORRECTION: could insure the registered of conduct the comprehensive ents when a significant change. The director of nursing could elated to the requirements pensive reassessments. The could develop a tool to audit ensure the appropriate completed at the time of these could be reviewed at a assurance meetings. R CORRECTION: Twenty-one					
21375	MN Rule 4658.0800 Program	O Subp. 1 Infection Control;	21375			9/15/15	
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.					
	This MN Requirements	ent is not met as evidenced					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		00501	B. WING		08/0	6/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•		
LYNGBL	OMSTEN CARE CEN	[FR	OND AVENUUL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 14	21375				
	review, the facility fa appropriate hand hy	on, interview and document ailed to ensure staff utilized ygiene during the provision of lents (R250) observed during ing.		Corrected			
	Findings include:						
	was observed comp R250. NA-B with glo do perineal care an soiled incontinent p NA-B removed her washing her hands the facility cell phor member. NA-B the removed her right g the hallway to look the door she put on R25's bedside to co	a.m. nursing assistant (NA)-B oleting perineal cares with oved hands assisted R250 to d attempted to remove R20's roduct which R250 refused. left glove, and without or using hand sanitizer, used be to contact another staff on went to the resident's door, allove, and opened the door to for help. When NA-B closed clean gloves and went to over R250 with bed linens and table. NA-B then removed her R250's room.					
	,	a.m. NA-B confirmed she had after glove removal or after .					
	stated during interv	a.m. registered nurse (RN)-B iew that staff are expected to ne after glove removal, and sident contact.					
	verified the facility p	p.m. the director of nursing protocol was for staff to ne after removal of gloves.					
	instructed staff to p	Hygiene policy dated 5/2013, erform hand hygiene after id before and after assisting					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00501	B. WING		08/0	06/2015
	PROVIDER OR SUPPLIER	TER 1415 ALM	DRESS, CITY, S IOND AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21375 21665	residents with personal revice policies hand hygiene could education. The director of nursiand revice policies hand hygiene could develop an a hand hygiene practiprovided. TIME PERIOD FOR (14) days.		21375			9/15/15
	functional, comforta environment, allowing personal belonging This MN Requirements by: Based on observative review, the facility of and appropriate may for 6 of 18 resident R139, R223, R399, R354, R357, R385) concerns. In addition dishwashers in 4 of facility were maintal addition, the facility disconnection switch area was activated use. This has the p (R40, R57, R59, R8)	ust provide a safe, clean, able, and homelike physical ng the resident to use is to the extent possible. ent is not met as evidenced on, interview and document ailed to ensure cleanliness aintenance to resident rooms rooms (R79, R114, R189, R69, R178, R183, R310, reviewed for environmental on, the facility failed to ensure is 8 kitchenettes throughout the ined in a sanitary manner. In failed to ensure the safety the for the stove in the cottage when the stove was not in otential to affect 18 of 18 in the safety of the stove was not in otential to affect 18 of 18 in the safety of the stove was not in otential to affect 18 of 18 in the safety of the saf		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00501	B. WING		08/0	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LYNGBL	OMSTEN CARE CENT	TFR	OND AVENUUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 16	21665			
	R4) residents identi	ified by staff as at risk.				
	Findings include:					
	environmental tour environmental serv member from physi during the tour. Dur environmental cond confirmed with the	1 p.m. to 1:52 p.m. an was conducted. The ices director (ESD) and a staff ical plant (PP) were presenting the tour the following terns were identified and ESD and PP staff member:				
	and peeling paint no	ne foot, which had chipped ear the doorjamb. The ESD I paint area created an e.				
	floor up approximat chipped and where near the doorjamb. paint area created a PP staff member re	all also had an area from the rely one foot which was paint was peeling and sticky. The ESD verified the chipped an uncleanable surface. The eported that a plastic guard the chipped paint must have				
	over approximately room. The bathroor approximately one paint. The ESD ver	lack scuff marks on the floor five feet on the left side of the m doorjambs from the floor up foot had chipped and peeling ified that the chipped paint eanable surface and that the ot homelike.				
	The areas were gra The ESD reported this but the resident	soiled build up on the carpet. by and had a dirty appearance. that the facility was aware of t would not allow staff to lings to clean the floor. Review				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		E SURVEY PLETED	
		00501	B. WING		08/	06/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER 1415 ALM	DDRESS, CITY, S' MOND AVENU AUL, MN 5510	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21665	of the resident's red documentation of second commentation of second	cord revealed no uch refusals. cuffed marks on the floor to entry way. There was peeling observed by the bathroom of floor up about one foot. The rechipped paint areas created research that the scuff marks up. In area where sheet rock was ately two feet in diameter on resident's recliner. There was refer time the end there were wheel chair SD verified that the exposed reated uncleanable surfaces marks should be cleaned up. In a rea where sheet rock was ately two feet in diameter on resident's recliner. There was refer to the time and there were wheel chair should be cleaned up. In a rea where sheet rock was ately two feet in diameter on resident's recliner. There was resident to resident the end of the tour, eight resident's as a series staff cleaned the recliner. There was resident to the tour, eight resident's recliner. The reported that one time a recliner that one time a recliner that one time are reported that one time are reported that one time are reported that one time are recliner. The reported that one time are reported that				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00501	B. WING		08/0	6/2015
-	PROVIDER OR SUPPLIER OMSTEN CARE CEN	TER 1415 ALM	DRESS, CITY, S' IOND AVENU UL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21665	They stated their proposed to fill paint/maintenance ESD. The ESD furt difficult for the staff being a second land. The facility's Maintenance ESD. The ESD furt difficult for the staff being a second land. The facility's Maintenance ESD. The ESD furt difficult for the staff being a second land. The facility's Maintenance ESD. The ESD furt difficult is maintenance. The facility's Maintenance ESD. The facility's Maintenance of the clip boat orders would be picted. The facility's Maintenance ESD. The facility's Maintenance of the clip boat orders would be picted. The facility's Maintenance ESD. The facility's Maintenance of the clip boat orders and presently season to complete the distribution. On 8/6/15, at 9:23 a kitchenettes was condicted to shad brown yether and brown yether expenses and drawer fund grime. Floors have baseboards. Right the baseboards and Ferstad noted to have heave outside of the dishwas outside of the dishw	rotocol was for the out a form for needed which they were to give to the her stated reports had been to complete due to English guage for many of the staff. enance Department Work ated 4/1985, indicated work cked up Monday through and 1:00 p.m. and work y being performed, would be ards outside the maintenance allow others not specifically ate the work orders. a.m. a tour of the facility's enducted with registered of the following issues were ators had dried on food the early being the total desired findings and inner doors. Freezer and inner doors. Freezer and brown to black build up at D-B verified findings and clean. of the Dorothea, Johnson, units, the dishwashers were y lime build up around the washers. RD-B verified the that staff were supposed to	21665			

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Minnesc	<u>ita Department of He</u>	ealth				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00501	B. WING	B. WING		6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
TW WILL OF	THO VIDE IT OIT OOF I EIE IT		IOND AVENU			
LYNGBL	OMSTEN CARE CENT	TFR	UL, MN 551			
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
21665	Continued From pa	ge 19	21665			
	any resident in the	area				
	any resident in the	arca.				
	Norway unit:					
		o.m. registered dietician				
		ed to leave the kitchenette on				
	,	h the stove unlocked. There				
	off when not in use.	n on the stove to "lock stove				
	off when not in use." - 2:41 p.m. trained medication aide (TMA)-C					
	washed dishes in sink next to stove, wiped off counters and left kitchenette at 2:44 p.m. with					
	stove unlocked.					
		assistant (NA)-D entered				
	kitchenette reached	d for something and then left				
		itered kitchenette washed				
		the sink, pass the stove and				
		amcup. NA-E then walked back				
		ve and filled cup with water				
		nette at 2:54 p.m. with the				
	stove unlocked.					
		enters kitchenette walked past estove remained unlocked.				
		ed nurse (RN)-H entered				
	kitchenette, when h	e left the area the stove				
	remained unlocked					
		entered kitchenette and used a				
	key and locked the	stove.				
	When intervioused a	on 8/4/15, at 3:04 p.m. TMA-D				
		they cook in the morning but				
		ok. I always come over and				
		the start of my shift. We need				
	to keep it off." TMA	-D verified he needed to lock				
		pecause "there is a concern for				
	the residents, R72	likes to come into the kitchen."				
	Roce unit:					
	Boss unit: On 8/4/15, at 2:46 r	o.m. observed the Boss unit				
		of have the power locked off.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00501	B. WING		08/0	06/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	rfr -	IOND AVENU IUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21665	RD-B was observed the kitchenette At 3:20 p.m. the B not locked off. NA-F kitchenette, but left During interview on stated that the stovoff. "I turned it off. I can. I probably turn week. If the burner might start a fire." Dorthea unit: During tour of Dorth 9:45 a.m. the stove power locked off. NAt 11:00 a.m. the stove power locked off. Nat 11:00 a.m. the stove power doff. Auxiliary unit: During a tour of the 8/6/15, at 10:35 a not be locked in the was in the kitchene When interviewed of stated "the people to (stove) on and then is the most commo Resident records we residents were identicated to transit the wheelchair around the wheelchair a	d to enter the area and stock oss unit stove power was still was observed in the without checking the stove. 8/4/15, at 3:59 p.m. NA-F e was suppose to be turned try to check it as much as I it off three to four times a knob were to get bumped, it mea kitchenette on 8/6/15, at was observed to not have the lo one was in the kitchenette. The average of the stove was observed to have Auxiliary unit kitchenette on meanth and the stove was observed to a power off position. No one atte. On 8/6/15, at 9:10 a.m. RD-B hat serve the meal turn them they key them off. Breakfast in time they use the stoves." The reviewed and the following tiffied as having severe int. 1/16/15, indicated R40 had pairment and required fer to the wheelchair. Once in resident was able to propel the	21665			

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00501	B. WING	B. WING		6/2015
					00/0	0/2010
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LVNGRI	OMSTEN CARE CENT	rer	OND AVENU			
LINGBL	OMOTEN CARE CENT	SAINT PA	UL, MN 551	08		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				,		
21665	Continued From pa	ge 21	21665			
		pairment and required				
	assistance to transf	er to the wheelchair. Once in				
	the wheelchair the r	resident was able to propel the				
	wheelchair around	the unit.				
	R59's MDS dated 7	7/1/15, indicated R59 had				
	severe cognitive im	pairment and required				
	assistance to transf	fer to the wheelchair. Once in				
	the wheelchair the i	resident was able to propel the				
	wheelchair around					
		7/22/15, indicated R87 had				
		pairment and required				
		er to the wheelchair. Once in				
		resident was able to propel the				
	wheelchair around					
		7/23/15, indicated R139 had				
		pairment and required				
		er to the wheelchair. Once in				
		resident was able to propel the				
	wheelchair around					
		indicated R283 had severe				
		nt and required assistance to				
		elchair. Once in the wheelchair				
	around the unit.	le to propel the wheelchair				
		5/21/15, indicated R310 had				
		pairment and required				
		fer to the wheelchair. Once in				
		resident was able to propel the				
	wheelchair around					
		5/21/15, indicated R225 had				
		pairment and was able to				
		chair around the unit.				
		7/9/15, indicated R128 had				
		pairment and required				
		fer to the wheelchair. Once in				
		resident was able to propel the				
	wheelchair around					
		6/24/15, indicated R340 had				
		pairment and required				
		er to the wheelchair. Once in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00501	B. WING		08/0	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CEN	TFR	OND AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21665	the wheelchair the wheelchair around R352's MDS dated severe cognitive im propel self in wheel was able to ambula unit. R227's MDS dated severe cognitive im assistance to transithe wheelchair around R107's MDS dated severe cognitive im propel their wheelch wheelchair around the unit with a walk R192's MDS dated severe cognitive im transfer self into wheelchair around R4's MDS dated 6/c cognitively intact but confused, requiring was able to transfer propel wheelchair around R72's MDS dated 6/c cognitively intact but confused, requiring was able to transfer propel wheelchair around R72's MDS dated 6/c cognitively intact but confused, requiring was able to transfer propel wheelchair around When interviewed of director of nursing skitchen are responsionant off. This may be	resident was able to propel the the unit. 6/3/15, indicated R352 had pairment and was able to chair around the unit. R352 te with a walker around the 6/3/15, indicated R227 had pairment and required fer to the wheelchair. Once in resident was able to propel the the unit. 5/20/15, indicated R107 had pairment and was able to hair around the unit, or walk on er. 6/3/15, indicated R192 had pairment and was able to heelchair and propel their the unit. 3/15, indicated R4 was at unit staff identified him as supervision if in kitchen. R4 ar self into wheelchair and tround the unit. R4 could walk the unit. 5/18/15, indicated R72 was at unit staff identified him as supervision if in kitchen. R72 ar self into wheelchair and tround the unit. R72 reself into wheelchair and tround the unit. R72 could walk the unit.	21665			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			3) DATE SURVEY COMPLETED	
		00501	B. WING		08/0	6/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LYNGBL	OMSTEN CARE CEN	TFR	OND AVENU UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
21665	Cooking, Serving a directions for staff: "b. Stove-turn on meals/cooking only i. If baking cake preheating the over remove pots/pans of ii. Please KE use/after meals!" SUGGESTED MET administrator could educate staff and ic safety, cleanliness could work with the ensure staff are repappropriately. Audiensure compliance	itled, A Neighborhood Guide to nd Storing Food included with key during e/cookies and you are nbe sure to check and often stored inside EY OFF STOVE when not in THOD OF CORRECTION: The review and revise the policies, dentify trends of environmental issues. The administrator director of nursing (DON) to porting environmental issues its could be conducted to	21665				
22000	Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may a and a statement of to minimize the risk comply with any rul promulgated by the	s population identifying encourage or permit abuse, specific measures to be taken to f abuse. The plan shall es governing the plan	22000			9/15/15	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00501	B. WING		08/0	6/2015
	PROVIDER OR SUPPLIER OMSTEN CARE CENT	1415 AI M	ORESS, CITY, S	STATE, ZIP CODE		
LINGBL	OWSTEN CARE CEN	SAINT PA	UL, MN 551	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	providers, shall dev prevention plan for residing there or recarding there or recarding there or residing there or recarding there or recarding there or recarding there or recarding the plan shall contain assessment of: (1) abuse by other indivulnerable adults; (1) other vulnerable aduspecific measures the risk of abuse to the adults. For the purplem "abuse" include (c) If the facility, and personal care a knows that the vuln violent crime or an atoward others, the inplan must detail the minimize the risk the reasonably be experiently and persons unsupervised. Under the plan must detail the minimize the risk the reasonably and persons unsupervised. Under the plan must detail the minimize the risk the reasonably of a vulnerable adumisconduct or physical information from authority or through another facility, and	al care attendant services relop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the	22000			
	by: Based on interview	and document review, the lement their Abuse Prevention		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00501	B. WING		08/0	6/2015
	PROVIDER OR SUPPLIER	TER 1415 ALM	DRESS, CITY, S OND AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	policy regarding scinewly employed embackground checks working with reside Findings include: The facility's Vulner Policy dated 3/2015 employment in the have the following s'a.) Reference chepast employer, b.) registry check, c.) (CBC) pursuant to Employees, volunte work pending the obeunder continuous have access to per results of the CBC employee being intervironment with viemployment will be Review of new hire 8/6/15 indicated emof 3/10/15. Review Clearance had a st the undated Nursin indicated E1's last of Review of the Back study date of 8/4/18	reening procedures for 2 of 5 aployees (E1, E2) whose is were not verified prior to ints. rable Adult/Abuse Prevention of, indicated all applicants for facility should, at a minimum, is creening check conducted: cks with the current and/or appropriate licensing board or criminal Background Check facility policy or State law i.) is ers and interns may begin autcome of the CBC, but must is, direct supervision if they sons receiving services. If the are returned with the eligible to work in this allorable adults, their terminated immediately." Ilist provided by the facility on apployee (E)-1 had a start date of the Background Study and date of 6/30/15. Review of g Department schedule for E1 orientation day was 3/16/15. Ilist provided by the facility on thad a start date of 7/14/15. Ilist provided by the facility on thad a start date of 7/14/15. Ilist provided by the facility on thad a start date of 7/14/15. Ilist provided by the facility on thad a start date of 7/14/15. Ilist provided by the facility on that a start date of 7/14/15. Ilist provided by the facility on that a start date of 7/14/15. Ilist provided by the facility on that a start date of 7/14/15. Ilist provided by the facility on that a start date of 7/14/15. Ilist provided by the facility on that a start date of 7/14/15. Ilist provided by the facility on the schedule for E2 indicated	22000			
		on 8/6/15, at 8:13 a.m. the esources (DHR) stated E1's				

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ___ 00501 08/06/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1415 ALMOND AVENUE** LYNGBLOMSTEN CARE CENTER

LYNGBLOMSTEN CARE CENTER SAINT PAUL, MN 55108							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
22000	Continued From page 26	22000					
	background check had been submitted to the Minnesota Department of Human Services on 6/27/15, 139 days after E1's start date. The DHR verified E1 would have been trained but would not have been supervised "for that length of time." The DHR confirmed E1's last training day was 3/16/15, and that E1 had been working unsupervised with residents since then.						
	During an interview on 8/6/15, at 8:57 a.m. the DHR stated E2's background check was submitted on 8/3/15, 20 days after E2's start date. The DHR verified E2 had been working with residents unsupervised since 7/22/15 and stated, "it would be a late submission, it was delinquent."						
	During an interview on 8/6/15, at 12:27 p.m. the director of nursing (DON) verified that background checks should have been completed prior to either of these staff being allowed to work independently with residents. The DON stated, "We are down to one person in HR (human resources), it was human oversight."						
	SUGGESTED METHOD OF CORRECTION: The administrator or designee could assess all residents in the facility for vulnerability of abuse risk factors and develop individual abuse prevention plans to minimize each residents risks for abuse. The administrator or designee could monitor for compliance.						
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						

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