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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TJUU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00501

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245347**
2.STATE VENDOR OR MEDICAID NO.
(L2) **009342400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/21/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 10/05/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/07/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245347	A. Building B. Wing	9/21/2015

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
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **09/15/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/15/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/15/2015**
ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **09/15/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/15/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **09/15/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **09/15/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GD/kfd	**Date:** 10/05/2015	**Signature of Surveyor:** 18623	**Date:** 09/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/6/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245347	A. Building B. Wing **01 - MAIN BUILDING 01**	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
ID Prefix	Correction Completed **09/15/2015**	ID Prefix	Correction Completed **09/15/2015**	ID Prefix	Correction Completed **09/15/2015**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0033	
ID Prefix	Correction Completed **09/15/2015**	ID Prefix	Correction Completed **09/15/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0038		Reg. # **NFPA 101** LSC K0062		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/kfd	10/05/2015	12424	10/02/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/6/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TJUU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00501

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245347**
2.STATE VENDOR OR MEDICAID NO.
(L2) **009342400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/06/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NE II 09/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

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

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.

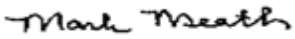
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	08/06/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	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 stated R61 was unable to get out of bed by	F 221	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 updated to reflect the removal of the swim	9/15/15

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

Electronically Signed | 08/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING _____ B. WING _____	08/06/2015

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F 221	Continued From page 1 herself. During an observation and interview with R61 in her room on 8/4/15 at 8:10 a.m. A perimeter mattress with cut out was observed on the bed. In addition it was noted there were two swim noodles laying under the right side of the mattress on the bed, raising the mattress and causing it to tip toward the wall. The swim noodles were noted to be in place again on 8/4/15, at 2:22 p.m. when R61 was observed laying in bed, leaning toward the wall on the left side. Her phone (on the overbed table next to the right side of the bed) was ringing at that time, and due to the position of the bed, R61 was observed to be unable to answer it. The surveyor alerted staff to assist her. On 8/5/15, at 9:30 a.m. the swim noodles 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,	F 221	noodle as a fall prevention intervention. Actions taken to identify other potential residents having similar occurrences: The use of swim noodles as a fall prevention intervention has been discontinued. All swim noodles in use have been removed and all swim noodles in supply have been destroyed. All affected residents care plans have been updated to reflect the removal of swim noodles as a fall prevention intervention. Measures put in place to ensure deficient practice does not occur: Central supply manager has been instructed to no longer inventory swim noodles. Clinical Manager and Supervisors have been educated to eliminate the practice of swim noodles as a fall intervention. Facility has implemented a Physical Device Evaluation tool to determine if any manual method or physical or mechanical device, material or equipment added to an individual¿s environment restricts freedom of movement or normal access to one¿ body and thereby considered a restraint. Any method or device determined to restrict movement or access to one¿s own body will require a Restraint Assessment and all the mandatory; consent, diagnoses, orders, trial reductions, releases, care plan interventions and other requirements necessary under §483.13(a). Effective implementation of actions will be monitored by: The Director of Nursing and/or his designee will monitor facility adherence to practices, polices and/or procedures and follow-up as indicated.	

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F 221	Continued From page 2 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 on Hospice care, and as having an un-repaired 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 fell...was 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.	F 221	Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete 3 audits each week for one month and then 2 audits every other week for two months to include proper compliance with procedures. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 221	Continued From page 3 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. And again on 6/17/15 at 6:16 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 note review did not identify when the use of the swim noodles had been initiated. The chart lacked identification of when initiated, and lacked documentation of any assessment of the swim noodles as potential restraints which were placed under the mattress to prevent R61 from getting out of bed. On 8/4/15, at 2:25 pm, RN-F stated the swim noodles had been placed under R61's mattress to give it a lift so she doesn't get out, because she had been found climbing out of bed a couple times. RN-F stated R16 had not been assessed for a restraint, since the facility didn't view the swim noodle use as a restraint,"she can still get out of bed. It [swim noodle] was put in as an intervention; the lipped mattress first, then if she continues to get out, you add the noodles." RN-F reviewed the chart with the surveyor and stated, "I cannot find when it was started [initiation of	F 221		

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F 221	Continued From page 4	F 221		

swim noodles to hold mattress up], the last fall intervention found was on 5/11/15, when she (R61) got up and walked over to turn the light off and fell trying to get back into bed, we added Tab alarm to call light system and there was a low bed."

On 8/4/15, at 2:39 p.m. the director of nursing (DON) stated she, "doubted the manufacturer of the lipped mattress or the bed would make recommendations for swim noodles." The DON further stated, "that intervention pre-dates me, I think they feel it is a small little addition to the lipped mattress." The DON also acknowledged that if a bed was put up against the wall on the strong side of a resident who has hemiparesis, that could be a form of restraint, but added "If RN-F says she is still able to get out of bed. I would not doubt that."

On 8/6/15, at 11:03 a.m., trained medication aide (TMA)-B stated, "The swim noodles, are used to keep her from going over the edge of the bed, by putting her legs over. I don't know who decides that. I think it's a nurse order. It just stays on the bed, once you put them on. It's just part of the equipment." When asked how she would know to use the swim noodles, TMA-B reviewed the nursing assistant care sheets and stated, "oh it's not here".
On 8/6/15, at 11:09 a.m., RN-G stated "the noodles are a fall intervention, it's an out of the box intervention, developed in a fall conference, long ago. We have used them for a long time, noodles are not to restrict movement, it's just to help remind the resident the edge of the bed is there." RN-G verified the noodles could be used even with a lipped mattress, "It's just because they (residents) continue to swing (legs) out of

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F 221	Continued From page 5	F 221		

the bed." When the surveyor asked RN-G how she would determine whether the swim noodle was a restraint for a resident without assessing, RN-G stated, "that's a good question."
On 8/6/15 at 2:00 p.m., the administrator and DON were interviewed. The DON stated the intention was to create a sense of perimeter for the individual, and the noodle had been effective in that practice. The DON said, "A restraint would cause limited movement, would limit access to her body, so we don't view it (the noodle) as a restraint." However the DON also stated, "It's kind of a circular argument that you don't know if it's a restraint if you don't assess it."
On 8/6/15, at 4:00 p.m. the DON provided information about the appropriate use of the noodles which included: hydrotherapy, aquatic therapy, pool noodles. "For aquatic exercise routines and rehabilitation."
The facility's Restraint Assessment Policy and Procedure was reviewed and included:
"Prior to a restraint being applied, a physical restraint assessment will be performed.
Purpose:
1. To evaluate individual resident' needs prior to use of any restraint
2. To protect resident's rights Procedure:
1.) Data collection and analysis of the following:
a. Medical diagnosis present
b. Physical Assessment
c. Cognitive status
d. Elimination pattern
e. Decision making skills
f. Behavior pattern
2.) Documentation of alternatives to restraints
3. Review of falls for times, place of occurrence and activity involved.

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F 221	Continued From page 6 4. Obtain physician order for medical diagnosis, type, reason for use, when to be used, check every 30 minutes and release every two hours with position change. 5. Update care plan and approaches 6. Place on the 24 hours sheet. 7. Review restraint use "	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		9/15/15

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F 225	Continued From page 7 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure employee background studies were conducted prior to employees working independently with residents for 2 of 5 newly employed employees (E1, E2) reviewed. Findings include: Review of new hire list provided by the facility on 8/6/15 indicated employee (E)-1 had a start date of 3/10/15. Review of the Background Study Clearance had a study date of 6/30/15. Review of the undated Nursing Department schedule for E1 indicated E1's last orientation day was 3/16/15. Review of new hire list provided by the facility on 8/6/15 indicated E2 had a start date of 7/14/15. Review of the Background Study Clearance had a study date of 8/4/15. Review of the undated Nursing Department schedule for E2 indicated E2's last orientation day was 7/22/15. During an interview on 8/6/15, at 8:13 a.m. the director of human resources (DHR) stated E1's 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	F 225	It is the policy of Lyngblomsten Care Center that the facility not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to staff identified, E1 and E2, background studies were completed and both were identified as able to provide direct contact services for this facility. Actions taken to identify other potential residents having similar occurrences: All employee records were reviewed to assure proper background studies were completed. Measures put in place to ensure deficient	

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F 225	Continued From page 8 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." The facility's Vulnerable Adult/Abuse Prevention Policy dated 3/2015, indicated all applicants for employment in the facility should, at a minimum, have the following screening check conducted: "a.) Reference checks with the current and/or past employer, b.) Appropriate licensing board or registry check, c.) Criminal Background Check (CBC) pursuant to facility policy or State law... i.) Employees, volunteers and interns may begin work pending the outcome of the CBC, but must be under continuous, direct supervision if they have access to persons receiving services. If the results of the CBC are returned with the employee being ineligible to work in this environment with vulnerable adults, their employment will be terminated immediately."	F 225	practice does not occur: Staff responsible for completing background studies were re-educated on the regulatory requirements. Staff responsible for the assignment and deployment of staff were educated on the requirement for background studies and 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, scheduling, and deployment of newly-hired staff. Effective implementation of actions will be monitored by: Director of Human Resources will monitor facility adherence to practices, polices and/or procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Human Resources and/or 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 Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		9/15/15

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F 226	Continued From page 9 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse Prevention policy regarding screening procedures for 2 of 5 newly employed employees (E1, E2) whose background checks were not verified prior to working with residents. Findings include: The facility's Vulnerable Adult/Abuse Prevention Policy dated 3/2015, indicated all applicants for employment in the facility should, at a minimum, have the following screening check conducted: "a.) Reference checks with the current and/or past employer, b.) Appropriate licensing board or registry check, c.) Criminal Background Check (CBC) pursuant to facility policy or State law... i.) Employees, volunteers and interns may begin work pending the outcome of the CBC, but must be under continuous, direct supervision if they have access to persons receiving services. If the results of the CBC are returned with the employee being ineligible to work in this environment with vulnerable adults, their employment will be terminated immediately." Review of new hire list provided by the facility on 8/6/15 indicated employee (E)-1 had a start date of 3/10/15. Review of the Background Study	F 226	It is the policy of Lyngblomsten Care Center that the facility develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to staff identified, E1 and E2, background studies were completed and both were identified as able to provide direct contact services for this facility. Actions taken to identify other potential residents having similar occurrences: All employee records were reviewed to assure proper background studies were completed. Measures put in place to ensure deficient practice does not occur: Staff responsible for completing background studies were re-educated on the regulatory requirements. Staff responsible for the assignment and deployment of staff were educated on the requirement for background studies and facility policy regarding training, supervision and direct contact of new staff. Current tracking system for new	

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F 226	Continued From page 10 Clearance had a study date of 6/30/15. Review of the undated Nursing Department schedule for E1 indicated E1's last orientation day was 3/16/15. Review of new hire list provided by the facility on 8/6/15 indicated E2 had a start date of 7/14/15. Review of the Background Study Clearance had a study date of 8/4/15. Review of the undated Nursing Department schedule for E2 indicated E2's last orientation day was 7/22/15. During an interview on 8/6/15, at 8:13 a.m. the director of human resources (DHR) stated E1's 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."	F 226	hires was enhanced to include background studies as a visible requirement for staff involved in the processing, orienting, training, scheduling, and deployment of newly hired staff. Effective implementation of actions will be monitored by: Director of Human Resources will monitor facility adherence to practices, polices and/or procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Human Resources and/or 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 Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		9/15/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 11 A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This 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: Dental: R244 was observed on 8/3/15, at 4:00 p.m. to have a broken tooth 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	F 274	It is the policy of Lyngblomsten Care Center that the facility conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in a resident¿s physical or mental condition. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident R244, a comprehensive oral assessment has been completed and his diet order and care plan have been updated to reflect his oral status and difficulty chewing. Regarding resident R178 a Significant Change MDS was completed and his care plan updated to reflect his change in mobility status.	

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F 274	Continued From page 12 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 surveyor and smiled. At the time R244 was noted to have teeth that appeared yellow and the front tooth on the lower jaw appeared broken. - At 8:35 a.m. to 9:03 a.m. R244 was observed eat his breakfast and appeared to be spending a long time chewing his food and appeared to be chew the bacon approximately two to three minutes between each bite compared to the scrambled eggs using his front teeth with a lot of chin and lip muscle activity. When approached and asked how the food was R244 stated it was good but indicated he needed help to cut up his two stripes of bacon. During the observation R244 was not observed to have any signs or symptoms of pain or discomfort with either eating or drinking. R244's Oral Assessment completed 7/6/14, indicated he did not have missing natural teeth; however, the Oral/Dental Status section on both the significant change Minimum Data Set (MDS) dated 4/1/15, indicated he had no dental concerns and the MDS indicated R244 had severely impaired cognition and required extensive physical assistance of one staff with brushing teeth. The Care Area Assessment (CAA) dated 4/3/15, failed to address R244's dental/oral health status. The facility failed to comprehensively assess R244's dental status. On 8/5/15, at 10:33 a.m. registered nurse (RN)-A who also was the MDS coordinator, stated the registered dietician (RD)-A completed Section L-Oral/Dental Status in the MDS. When asked if	F 274	Actions taken to identify other potential residents having similar occurrences: All resident care plans have been reviewed for accuracy. All changes in resident mental and physical conditions are reviewed as part of the weekly IDT process on each neighborhood. Any noted changes are analyzed for required interventions; assessments, care plan updates, physician and/or family notifications, etc. and appropriate actions taken, including a Significant Change MDS. Measures put in place to ensure deficient practice does not occur: Staff have been re-educated on informing appropriate lead personnel on resident changes; e.g. If a resident has increased difficulty chewing they are to notify their nursing supervisor. Change in condition policy was reviewed with all appropriate staff. A new integrated oral assessment was developed in the facility Electronic Health Record allowing coordinated completion by a multidisciplinary team. MDS Coordinators have been re-educated on the change requirements that define a significant change. Effective implementation of actions will be monitored by: The Director of Nursing will monitor facility adherence to practices, polices and/or procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete 2 audits each week for one month and then 2 audits every other week for two months to include proper	

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F 274	Continued From page 13 there was a tool RD-A used when doing the oral visual assessment she looked at surveyor and stated she was going to call the RD-A. On the phone RN-A was overheard to indicate she had reviewed the significant change MDS dated 4/1/15, and had not seen an assessment. RN-A indicated after she got off the phone RD-A had indicated she looked at the nursing oral assessment from when resident was admitted to the facility and that was how she had completed the assessment. - At 10:42 a.m. RD-A stated she completed the MDS based on the nursing oral assessment and if anything came up in regards to a change in dental status it would be communicated to her by staff. RD-A acknowledged she had completed the MDS based on the Oral Assessment dated 7/6/15, which had indicated R244 had no teeth problems yet he had a broken tooth. RD-A further stated she did not do an actual oral assessment and would not be able to know if R244 had any broken or missing teeth. -At 10:45 a.m. RN-A stated she would have expected the MDS to be accurate and to have captured all the dental concerns R244 had if any. RN-A further stated "I sign off on the MDS's and I relay on staff to complete various sections it's an interdisciplinary effort." On 8/6/15, at 10:54 a.m. nursing assistant (NA)-A stated she usually assisted R244 with all of his cares in the morning which included brushing his teeth. NA-A indicated when it came to brushing R244's teeth he would attempt to brush them but she had to assist him more in order to get both the upper and lower jaws. NA-A further stated from her recollection she had noted R244 had always some missing and/or broken teeth in his mouth but was not sure where and how many.	F 274	compliance with procedures. The data collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	

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- At 12:04 p.m. the director of nursing (DON) stated "we have to do an assessment and we have to continue to attempt to do assessments for residents like him who refuse and have to make adjustments" DON acknowledged the oral assessment had been missed in the beginning and added the facility was working on getting all the assessments to Point Click Care (PCC-electronic health record) which would be more friendly to monitor all the assessments. DON further stated he would have expected the MDS to be accurate and the facility was looking into getting or having a dental hygienist come in to do all the oral assessments periodically.

Dental Services policy revised 4/30/08, indicated "3. "Routine dental services" include an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning..." The policy did not indicate who in the facility was responsible for completing the oral visual assessment and who ensured that was completed and was accurate to indicate the current oral status of the resident.

According to the Long Term Care Facility Resident Assessment Instrument version 3.0 last revised on October 2014, the steps for assessment included:
" 1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort.
2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.)
3. If the resident has dentures or partials,

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F 274	Continued From page 15 examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment. 4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth. 5. If the resident is unable to self-report, then observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present. 6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues." Improvement: R178 was observed on 8/5/15, at 8:00 a.m. in the dining room. R178 pushed himself away from the breakfast table and stood up. He went to the other side of the dining room to retrieve his walker. His stature was slightly slumped forward and the gait was steady. R178 ambulated out the dining without staff assist. The admission MDS dated 9/12/14, indicated R178's cognitive score was 9 (moderate cognitive impairment). The MDS identified R178 required extensive assistance of one staff member to walk in and out of room, locomotion on and off the unit; Supervision and setup with eating. R178 was	F 274		

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identified as having no impairment in functional range of motion for his arms or legs.

The quarterly MDS dated 6/11/15, indicated cognition had improved to a score of 15 (cognitively intact). R178's ability to walk in room and out of room, locomotion on and off unit had improved to independent without any setup by staff, and eating had improved to independent after set up. R178 was identified as having impairment in functional range of motion on one arm. The medical record lacked evidence of a significant change MDS being completed for the improvements R178 had with ambulation in room and on the unit, eating, and cognition.

On 8/5/15, at 2:55 p.m. RN-A reviewed R178's admission and quarterly MDS's and supporting documentation for cognition and activities of daily living and acknowledged R178 should have had a Significant Change MDS completed. RN-A stated she had viewed all locomotion as one change, and with current cognition score now he had two changes. Agreed that it was four different areas on the MDS but practically looked at as one. RN-A verified the clinical record lacked evidence the significant change in status was considered for the quarterly MDS on 6/11/15.

According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires

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F 274	Continued From page 17 interdisciplinary review and/or revision of the care plan." In addition, a significant change should be completed for improvement as followed: Improvement in two or more of the following: " - Any improvement in an ADL physical functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment; - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases; - Resident's decision making changes for the better; - Resident's incontinence pattern changes for the better; - Overall improvement of resident's condition."	F 274		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the safety disconnection switch for the stove in the cottage area was activated when the stove was not in use. This has the potential to affect 18 of 18 (R40, R57, R59, R87, R139, R283, R310, R225, R128 R340, R352, R227, R107, R192, R4, R72,	F 323	It is the policy of Lyngblomsten Care Center that the facility ensure that the resident environment remains as free of accident hazards as is possible; each resident receives adequate supervision and assistance devices to prevent accidents. To assure continued	9/15/15

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F 323	Continued From page 18 R4) residents identified by staff as at risk. Findings include: During a continous observation on 8/4/15, from 2:28 p.m. to 3:04 p.m. the stove in the Norway unit kitchenette was observed to be unlocked (power on to stove), which had the potential to allow the burners and oven to be turned on by any resident in the area. Norway unit: On 8/4/15, at 2:28 p.m. registered dietician (RD)-B was observed to leave the kitchenette on the Norway unit with the stove unlocked. There was an undated sign 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. -2:44 p.m. nursing assistant (NA)-D entered kitchenette reached for something and then left kitchenette with stove unlocked. -2:51 p.m. NA-E entered kitchenette washed hands, walked from the sink, pass the stove and got ice in a styrofoamcup. NA-E then walked back to sink, passing stove and filled cup with water then left the kitchenette at 2:54 p.m. with the stove unlocked. -3:02 p.m. TMA-C enters kitchenette walked past sink and stove. The stove remained unlocked. -3:03 p.m. registered nurse (RN)-H entered kitchenette, when he left the area the stove remained unlocked. -3:04 p.m. TMA-D entered kitchenette and used a key and locked the stove. When interviewed on 8/4/15, at 3:04 p.m. TMA-D	F 323	compliance the following plan has been implemented. Regarding cited residents: With respect to the 18 residents listed, see below for system changes that will assure their safety regarding stove use on each neighborhood. Actions taken to identify other potential residents having similar occurrences: All cognitively impaired mobile residents were identified. Each is potentially at risk for injury related to stove use on each neighborhood, see below. Measures put in place to ensure deficient practice does not occur: The facility has replaced all stove disconnect switches with new ¿key¿ style switches which are more definitive in their switch action. The switch indicator lights have been replaced with brighter more recognizable lights. Facility policy regarding stove use and the required safety precautions has been updated to reflect the need to assure power has been disconnected before leaving the stove unsupervised. Staff have been educated on these policy and procedure updates. Effective implementation of actions will be monitored by: The Director of Nursing will monitor facility adherence to practices, polices and/or procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will complete 7 audits each week for one month and then 7 audits every other week for two months to include proper compliance with procedures. The data	

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F 323	Continued From page 19 stated that usually they cook in the morning but added, "I do not cook. I always come over and check the stove at the start of my shift. We need to keep it off." TMA-D verified he needed to lock the stove off often because "there is a concern for the residents, R72 likes to come into the kitchen." Boss unit: On 8/4/15, at 2:46 p.m. observed the Boss unit was observed to not have the power locked off. RD-B was observed to enter the area and stock the kitchenette. - At 3:20 p.m. the Boss unit stove power was still not locked off. NA-F was observed in the kitchenette, but left without checking the stove. During interview on 8/4/15, at 3:59 p.m. NA-F stated that the stove was suppose to be turned off. "I turned it off. I try to check it as much as I can. I probably turn it off three to four times a week. If the burner knob were to get bumped, it might start a fire." Dorthea unit: During tour of Dorthea kitchenette on 8/6/15, at 9:45 a.m. the stove was observed to not have the power locked off. No one was in the kitchenette. At 11:00 a.m. the stove was observed to have been powered off. Auxiliary unit: During a tour of the Auxiliary unit kitchenette on 8/6/15, at 10:35 a..m. the stove was observed to not be locked in the power off position. No one was in the kitchenette. When interviewed on 8/6/15, at 9:10 a.m. RD-B stated "the people that serve the meal turn them (stove) on and then they key them off. Breakfast	F 323	collected will be presented to the Quality Assurance committee by the Director of Nursing. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 323	Continued From page 20 is the most common time they use the stoves." Resident records were reviewed and the following residents were identified as having severe cognitive impairment. R40's MDS dated 7/16/15, indicated R40 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit. R57's MDS dated 7/15/15, indicated R57 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit. R59's MDS dated 7/1/15, indicated R59 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit. R87's MDS dated 7/22/15, indicated R87 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit. R139's MDS dated 7/23/15, indicated R139 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit. R283 dated 6/9/15, indicated R283 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit. R310's MDS dated 5/21/15, indicated R310 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the	F 323		

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wheelchair around the unit.
R225's MDS dated 5/21/15, indicated R225 had severe cognitive impairment and was able to propel self in wheelchair around the unit.
R128's MDS dated 7/9/15, indicated R128 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R340's MDS dated 6/24/15, indicated R340 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R352's MDS dated 6/3/15, indicated R352 had severe cognitive impairment and was able to propel self in wheelchair around the unit. R352 was able to ambulate with a walker around the unit.
R227's MDS dated 6/3/15, indicated R227 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R107's MDS dated 5/20/15, indicated R107 had severe cognitive impairment and was able to propel their wheelchair around the unit, or walk on the unit with a walker.
R192's MDS dated 6/3/15, indicated R192 had severe cognitive impairment and was able to transfer self into wheelchair and propel their wheelchair around the unit.
R4's MDS dated 6/3/15, indicated R4 was cognitively intact but unit staff identified him as confused, requiring supervision if in kitchen. R4 was able to transfer self into wheelchair and propel wheelchair around the unit. R4 could walk with walker around the unit.
R72's MDS dated 6/18/15, indicated R72 was

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F 323	Continued From page 22 cognitively intact but unit staff identified him as confused, requiring supervision if in kitchen. R72 was able to transfer self into wheelchair and propel wheelchair around the unit. R72 could walk with walker around the unit. When interviewed on 8/6/15, at 11:10 a.m. the director of nursing stated "the people in the kitchen are responsible for turning the stove on and off. This may be nursing, housekeeping, assistant administrator. Whoever was cooking is responsible." An undated policy titled, A Neighborhood Guide to Cooking, Serving and Storing Food included directions for staff: ... "b. Stove-turn on with key during meals/cooking only! i. If baking cake/cookies and you are preheating the oven--be sure to check and remove pots/pans often stored inside ii. Please KEY OFF STOVE when not in use/after meals!"	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		9/15/15

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff utilized appropriate hand hygiene during the provision of care for 1 of 3 residents (R250) observed during activities of daily living. Findings include: On 8/5/15, at 8:34 a.m. nursing assistant (NA)-B was observed completing perineal cares with R250. NA-B with gloved hands assisted R250 to do perineal care and attempted to remove R20's	F 441	It is the policy of Lyngblomsten Care Center that the facility establish and maintain an infection control program designed to provide a safe, sanitary and 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 compliance	

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F 441	Continued From page 24 soiled incontinent product which R250 refused. NA-B removed her left glove, and without washing her hands or using hand sanitizer, used the facility cell phone to contact another staff member. NA- B then went to the resident's door, removed her right glove, and opened the door to the hallway to look for help. When NA-B closed the door she put on clean gloves and went to R25's bedside to cover R250 with bed linens and make R250 comfortable. NA-B then removed her gloves and exited R250's room. On 8/5/15, at 8:43 a.m. NA-B confirmed she had not washed her hands after glove removal or after leaving R25's room. On 8/5/15, at 8:47 a.m. registered nurse (RN)-B stated during interview that staff are expected to conduct hand hygiene after glove removal, and before and after resident contact. On 8/6/15, at 12:36 p.m. the director of nursing verified the facility protocol was for staff to conduct hand hygiene after removal of gloves. The facility's Hand Hygiene policy dated 5/2013, instructed staff to perform hand hygiene after removing gloves and before and after assisting residents with personal cares.	F 441	the following plan has been implemented. Regarding cited residents: With respect to resident R250 (actually R79- evidence wrongly identified resident), she was monitored to assure no negative outcomes resulted from the infection control breach. Resident currently infection free. Actions taken to identify other potential residents having similar occurrences: All residents receiving direct care are at risk for infection if proper infection control practices are not maintained. To assure continued compliance, see system measures below. Measures put in place to ensure deficient practice does not occur: All staff have been re-educated on proper infection control practices with particular focus on hand washing process and sequence. Infection surveillance and tracking continue and analysis of data used to determine if staff practices are contributing to the development and transmission of infection. New data analysis includes infection data cross referenced by area with specific staffing to determine if trending can be attributed to specific staff. Effective implementation of actions will be monitored by: Infection Preventionist will monitor facility adherence to practices, polices and/or procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Infection Preventionist and/or designee will complete 5 audits each week for one month and then 5 audits	

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F 441	Continued From page 25	F 441	every other week for two months to include proper compliance with procedures. The data collected will be presented to the Quality Assurance committee by the Infection Preventionist. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cleanliness and appropriate maintenance to resident rooms for 6 of 18 resident rooms (R79, R114, R189, R139, R223, R399, R69, R178, R183, R310, R354, R357, R385) reviewed for environmental concerns. In addition, the facility failed to ensure dishwashers in 4 of 8 kitchenettes throughout the facility were maintained in a sanitary manner. Findings include: On 8/6/15, from 1:11 p.m. to 1:52 p.m. an environmental tour was conducted. The environmental services director (ESD) and a staff member from physical plant (PP) were present	F 465	It is the policy of Lyngblomsten Care Center that the facility provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. To assure continued compliance the following plan has been implemented. Regarding cited residents: With respect to resident the 6 residents cited for cleanliness and maintenance, all areas of concern related to peeling and/or chipped paint, scuff marks, soiled carpet, and damaged sheetrock have been repaired and/or cleaned. With respect to the 8 residents cited for dust covered bathroom vents, all vents have been removed, thoroughly cleaned and	9/15/15

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F 465	Continued From page 26 during the tour. During the tour the following environmental concerns were identified and confirmed with the ESD and PP staff member: R79's bathroom wall had an area from the floor up approximately one foot, which had chipped and peeling paint near the doorjamb. The ESD verified the chipped paint area created an uncleanable surface. R114's bathroom wall also had an area from the floor up approximately one foot which was chipped and where paint was peeling and sticky near the doorjamb. The ESD verified the chipped paint area created an uncleanable surface. The PP staff member reported that a plastic guard previously covering the chipped paint must have fallen off. R189's room had black scuff marks on the floor over approximately five feet on the left side of the room. The bathroom doorjambs from the floor up approximately one foot had chipped and peeling paint. The ESD verified that the chipped paint areas were not a cleanable surface and that the scuff marks were not homelike. R139's room had a soiled build up on the carpet. The areas were gray and had a dirty appearance. The ESD reported that the facility was aware of this but the resident would not allow staff to remove her furnishings to clean the floor. Review of the resident's record revealed no documentation of such refusals. R223's room had scuffed marks on the floor to the right side of the entry way. There was peeling and chipped paint observed by the bathroom doorjambs from the floor up about one foot. The	F 465	replaced. All kitchenette refrigerators, freezers, and cabinet doors and drawer fronts have been cleaned. Kitchenette floors, including baseboards have been contracted to be cleaned and are scheduled to be completed by 9-31-15. Dishwashers on Dorothea, Koller, and Fergstad neighborhoods have been de-limed. Actions taken to identify other potential residents having similar occurrences: Environmental audits have been completed for all areas of the building to note any areas of concern related to cleanliness, maintenance, and function of the facility environment. All areas and equipment noted needing attention were identified and plans developed for timely repair and/or cleaning. Measures put in place to ensure deficient practice does not occur: Staff were re-educated on the requirement to maintain a safe, functional, sanitary and comfortable environment and the process for identifying and communicating any areas of concern related to that requirement to the appropriate responsible party. Physical Plant and Environmental Services have reviewed and enhanced existing maintenance and cleaning schedules to assure items/areas needing service/repair are addressed on a schedule. Facility systems for identifying and communicating staff identified needs (work orders) have been digitized allowing for improved tracking and monitoring. Effective implementation of actions will be monitored by:	

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F 465	Continued From page 27 ESD verified that the chipped paint areas created uncleanable surfaces and that the scuff marks should be cleaned up. R399's room had an area where sheet rock was exposed approximately two feet in diameter on the wall behind the resident's recliner. There was also an area on the left side of the room approximately one foot up the wall where there was missing paint, and there were wheel chair scuff marks. The ESD verified that the exposed sheet rock areas created uncleanable surfaces and that the scuff marks should be cleaned up. During the tour, the PP staff member reported there had been a work order submitted for the repairs, but was not able to supply a copy of the work orders. Additionally during the tour, eight resident's bathroom (R69, R139, R178, R183, R310, R354, R357, R385) vents were observed to be covered with a heavy layer of dust. The PP staff member reported that one time a year their department's staff cleaned the ventilation system and vents, but could not confirm whether the cleaning had been completed yet this year. On 8/6/15, at 1:53 p.m. the ESD and PP staff member reported there was no formal preventative maintenance program for the facility. They stated their protocol was for the housekeeper to fill out a form for needed paint/maintenance which they were to give to the ESD. The ESD further stated reports had been difficult for the staff to complete due to English being a second language for many of the staff.	F 465	Administrator will monitor facility adherence to practices, polices and/or procedures and follow-up as indicated. Those responsible to maintain compliance will be: The Administrator and/or designee will complete 3 audits each week for one month and then 3 audits every other week for two months to include proper compliance with procedures. The data collected will be presented to the Quality Assurance committee by the Administrator. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.	

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F 465	Continued From page 28 The facility's Maintenance Department Work Order Procedure dated 4/1985, indicated work orders would be picked up Monday through Friday at 8:00 a.m. and 1:00 p.m. and work orders not presently being performed, would be kept on the clip boards outside the maintenance office which would allow others not specifically assigned to complete the work orders. On 8/6/15, at 9:23 a.m. a tour of the facility's kitchenettes was conducted with registered dietitian (RD)-B and the following issues were identified: Refrigerators had dried on food splattered on shelves and inner doors. Freezer seals had brown yellow build up in them. Cabinet doors and drawer fronts had sticky areas of built up grime. Floors had brown to black build up at the baseboards. RD-B verified findings kitchenettes were not clean. During observation of the Dorothea, Johnson, Koller and Ferstad units, the dishwashers were noted to have heavy lime build up around the outside of the dishwashers. RD-B verified the findings and stated that staff were supposed to de-lime the dishwashers once a week.	F 465		

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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. 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	K 000	EPOC	

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

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.

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K 000	Continued From page 1	K 000		

Or by email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence 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.

The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. All resident rooms are equipped with single station smoke detection. The facility has a capacity of 237 beds and had a census of 225 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not have a corridor door that meets the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents within the smoke compartment. Findings include: On facility tour between 09:00 AM and 02:00 PM on 08/06/2015, it was observed that the corridor	K 018	K018 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 101 LSC (00) Section 19.3.6.3.2, the doors to the 3rd floor east dining room have been scheduled for replacement. Doors have been ordered and are due to arrive and be replaced no later than 9-29-15. Door replacement installation will be performed by licensed contracted agency. Physical	9/15/15

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K 018	Continued From page 3 doors to the 3rd floor E. Dining Room did not latch when tested. This deficient practice was verified by the facility staff (CA), at the time of discovery.	K 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.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 09:00 AM and 02:00 PM on 08/06/2015, it was observed that there were penetrations in the corridor wall and doors that did not latch in the following areas: 1) 1st floor Laundry Room door to corridor did not latch when tested. 2) 3rd floor Janitor room A-324had a penetration	K 029	K029 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 101-2000 edition, Section 19.3.2.1 and 8.4.1, the following actions have been taken: 1. The 1st floor laundry room door was adjusted on 8-6-15 for proper closure and latch. 2. The 3rd floor janitor room A-324 penetration area on wall around conduit has been appropriately filled with a fire rated caulk on 8-27-15 3. The 3rd floor janitor room adjacent to room A350 opening between soiled utility	9/15/15

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K 029	Continued From page 4 in the corridor wall around conduit. 3) 3rd floor janitor room to Soiled Utility room across from room A-350 had a 4" hole around pipe. 4) Lower level TV storage room doors did not self close and latch when tested. 5) Lower level Red Bag storage room doors did not self close and latch when tested. This deficient practice was verified by the facility staff (CA), at the time of discovery.	K 029	room is to be appropriately filled by 9-4-15. Facility staff are completing the repair. 4. The lower level television storage area doors have had appropriate closure devices installed on 8-24-15 and now self-close and latch appropriately. 5. The lower level red bag storage room have had appropriate closure devices installed on 8-24-15 and now self-close and latch appropriately. Physical Plant Director will oversee the completion of all work required and will perform routine audits of related areas and equipment function.	
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect all 76 residents. Findings include: On facility tour between 09:00 AM and 02:00 PM on 08/06/2015, it was observed that 3C stairwell	K 033	K033 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 101-200 edition, Sections 19.3.1.1, 8.2.5, all wall penetrations in 3C stairwell will be appropriately filled with a fire rated sealing caulking on 9-4-15. The Physical Plant Director will observe and maintain all wall penetrations per appropriate code	9/15/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 033	Continued From page 5 wall to the corridor had a penetration around conduit through the wall. This deficient practice was verified by the facility staff (CA), at the time of discovery.	K 033	standards.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to provide a proper exit to the outside. This deficient practice could affect the safe and rapid evacuation of all residents, visitors and staff in the event of an emergency that may require quick evacuation in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 09:00 AM and 02:00 PM on 08/06/2015, it was observed that the1st floor C exit door to the outside was difficult to open and took several attemps to jar the door open. This deficient practice was verified by the facility staff (CA), at the time of discovery.	K 038	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 been adjusted to open easily, adjustments completed on 8-6-15. The Physical Plant Director will inspect all exit doors monthly for proper operation.	9/15/15
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25,	K 062		9/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/06/2015**

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K 062	Continued From page 6 9.7.5 This STANDARD is not met as evidenced by: Based on observation, and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 09:00 AM and 02:00 PM on 08/06/2015, it was observed that there was no sprinkler wrench in the spare head box on in the facility. This deficient practice was verified by the facility staff (CA), at the time of discovery.	K 062	K062 To meet the requirement of 42CFR, Subpart 483.70(a), NFPA 25(99) Section 9.2.7, the sprinkler wrench has been ordered and will be replaced in the spare head box by 9-15-15. The Physical Plant Director will observe periodically to assure the wrench is available in the spare head box.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00501	A. BUILDING: _____ B. WING _____	08/06/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000	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.	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 8/3/15 through 8/6/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and	2 530		9/15/15

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2 530	Continued From page 2 circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to 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 stated R61 was unable to get out of bed by herself. During an observation and interview with R61 in her room on 8/4/15 at 8:10 a.m. A perimeter mattress with cut out was observed on the bed. In addition it was noted there were two swim noodles laying under the right side of the mattress on the bed, raising the mattress and causing it to tip toward the wall. The swim noodles were noted to be in place again on 8/4/15, at 2:22 p.m. when R61 was observed laying in bed, leaning toward the wall on the left side. Her phone (on the overbed table next to the right side of the bed) was ringing at that time, and due to the position of the bed, R61 was observed to be unable to answer it. The surveyor alerted staff to assist her. On 8/5/15, at 9:30 a.m. the swim noodles	2 530	Corrected	

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2 530	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 on Hospice care, and as having an un-repaired	2 530		

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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 [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 fell...was 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. And again on 6/17/15 at 6:16 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		

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2 530	Continued From page 5 The chart lacked identification of when initiated, and lacked documentation of any assessment of the swim noodles as potential restraints which were placed under the mattress to prevent R61 from getting out of bed. On 8/4/15, at 2:25 pm, RN-F stated the swim noodles had been placed under R61's mattress to give it a lift so she doesn't get out, because she had been found climbing out of bed a couple times. RN-F stated R16 had not been assessed for a restraint, since the facility didn't view the swim noodle use as a restraint,"she can still get out of bed. It [swim noodle] was put in as an intervention; the lipped mattress first, then if she continues to get out, you add the noodles." RN-F reviewed the chart with the surveyor and stated, "I cannot find when it was started [initiation of swim noodles to hold mattress up], the last fall intervention found was on 5/11/15, when she (R61) got up and walked over to turn the light off and fell trying to get back into bed, we added Tab alarm to call light system and there was a low bed." On 8/4/15, at 2:39 p.m. the director of nursing (DON) stated she, "doubted the manufacturer of the lipped mattress or the bed would make recommendations for swim noodles." The DON further stated, "that intervention pre-dates me, I think they feel it is a small little addition to the lipped mattress." The DON also acknowledged that if a bed was put up against the wall on the strong side of a resident who has hemiparesis, that could be a form of restraint, but added "If RN-F says she is still able to get out of bed. I would not doubt that." On 8/6/15, at 11:03 a.m., trained medication aide (TMA)-B stated, "The swim noodles, are used to	2 530		

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2 530	Continued From page 6 keep her from going over the edge of the bed, by putting her legs over. I don't know who decides that. I think it's a nurse order. It just stays on the bed, once you put them on. It's just part of the equipment." When asked how she would know to use the swim noodles, TMA-B reviewed the nursing assistant care sheets and stated, "oh it's not here". On 8/6/15, at 11:09 a.m., RN-G stated "the noodles are a fall intervention, it's an out of the box intervention, developed in a fall conference, long ago. We have used them for a long time, noodles are not to restrict movement, it's just to help remind the resident the edge of the bed is there." RN-G verified the noodles could be used even with a lipped mattress, "It's just because they (residents) continue to swing (legs) out of the bed." When the surveyor asked RN-G how she would determine whether the swim noodle was a restraint for a resident without assessing, RN-G stated, "that's a good question." On 8/6/15 at 2:00 p.m., the administrator and DON were interviewed. The DON stated the intention was to create a sense of perimeter for the individual, and the noodle had been effective in that practice. The DON said, "A restraint would cause limited movement, would limit access to her body, so we don't view it (the noodle) as a restraint." However the DON also stated, "It's kind of a circular argument that you don't know if it's a restraint if you don't assess it." On 8/6/15, at 4:00 p.m. the DON provided information about the appropriate use of the noodles which included: hydrotherapy, aquatic therapy, pool noodles. "For aquatic exercise routines and rehabilitation." The facility's Restraint Assessment Policy and Procedure was reviewed and included: "Prior to a restraint being applied, a physical restraint assessment will be performed.	2 530		

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2 530	Continued From page 7 Purpose: 1. To evaluate individual resident' needs prior to use of any restraint 2. To protect resident's rights Procedure: 1.) Data collection and analysis of the following: a. Medical diagnosis present b. Physical Assessment c. Cognitive status d. Elimination pattern e. Decision making skills f. Behavior pattern 2.) Documentation of alternatives to restraints 3. Review of falls for times, place of occurrence and activity involved. 4. Obtain physician order for medical diagnosis, type, reason for use, when to be used, check every 30 minutes and release every two hours with position change. 5. Update care plan and approaches 6. Place on the 24 hours sheet. 7. Review restraint use " SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure potential restraints are identified, comprehensively assessed and care planned to ensure the use of least restrictive restraints. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 530		

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2 545	Continued From page 8	2 545		
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 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: 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 surveyor and smiled. At the time R244 was noted	2 545	Corrected	9/15/15

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2 545	Continued From page 9	2 545		

to be missing teeth to the right lower jaw and teeth appeared yellow and the front tooth on the lower jaw appeared broken.
- At 8:35 a.m. to 9:03 a.m. R244 was observed eat his breakfast and appeared to be spending a long time chewing his food and appeared to be chew the bacon approximately two to three minutes between each bite compared to the scrambled eggs using his front teeth with a lot of chin and lip muscle activity. When approached and asked how the food was R244 stated it was good but indicated he needed help to cut up his two stripes of bacon. During the observation R244 was not observed to have any signs or symptoms of pain or discomfort with either eating or drinking.

R244's Oral Assessment completed 7/6/14, indicated he did not have missing natural teeth; however, the Oral/Dental Status section on both the significant change Minimum Data Set (MDS) dated 4/1/15, indicated he had no dental concerns and the MDS indicated R244 had severely impaired cognition and required extensive physical assistance of one staff with brushing teeth. The Care Area Assessment (CAA) dated 4/3/15, failed to address R244's dental/oral health status. The facility failed to comprehensively assess R244's dental status.

On 8/5/15, at 10:33 a.m. registered nurse (RN)-A who also was the MDS coordinator, stated the registered dietician (RD)-A completed Section L-Oral/Dental Status in the MDS. When asked if there was a tool RD-A used when doing the oral visual assessment she looked at surveyor and stated she was going to call the RD-A. On the phone RN-A was overheard to indicate she had reviewed the significant change MDS dated 4/1/15, and had not seen an assessment. RN-A

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indicated after she got off the phone RD-A had indicated she looked at the nursing oral assessment from when resident was admitted to the facility and that was how she had completed the assessment.
- At 10:42 a.m. RD-A stated she completed the MDS based on the nursing oral assessment and if anything came up in regards to a change in dental status it would be communicated to her by staff. RD-A acknowledged she had completed the MDS based on the Oral Assessment dated 7/6/15, which had indicated R244 had no teeth problems yet he had several missing teeth. RD-A further stated she did not do an actual oral assessment and would not be able to know if R244 had any broken or missing teeth.
-At 10:45 a.m. RN-A stated she would have expected the MDS to be accurate and to have captured all the dental concerns R244 had if any. RN-A further stated "I sign off on the MDS's and I relay on staff to complete various sections it's an interdisciplinary effort."

On 8/6/15, at 10:54 a.m. nursing assistant (NA)-A stated she usually assisted R244 with all of his cares in the morning which included brushing his teeth. NA-A indicated when it came to brushing R244's teeth he would attempt to brush them but she had to assist him more in order to get both the upper and lower jaws. NA-A further stated from her recollection she had noted R244 had always some missing teeth in his mouth but was not sure where and how many.
- At 12:04 p.m. the director of nursing (DON) stated "we have to do an assessment and we have to continue to attempt to do assessments for residents like him who refuse and have to make adjustments" DON acknowledged the oral assessment had been missed in the beginning and added the facility was working on getting all

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2 545	Continued From page 11 the assessments to Point Click Care (PCC-electronic health record) which would be more friendly to monitor all the assessments. DON further stated he would have expected the MDS to be accurate and the facility was looking into getting or having a dental hygienist come in to do all the oral assessments periodically. Dental Services policy revised 4/30/08, indicated "3. "Routine dental services" include an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning..." The policy did not indicate who in the facility was responsible for completing the oral visual assessment and who ensured that was completed and was accurate to indicate the current oral status of the resident. Improvement: R178 was observed on 8/5/15, at 8:00 a.m. in the dining room. R178 pushed himself away from the breakfast table and stood up. He went to the other side of the dining room to retrieve his walker. His stature was slightly slumped forward and the gait was steady. R178 ambulated out the dining without staff assist. The admission MDS dated 9/12/14, indicated R178's cognitive score was 9 (moderate cognitive impairment). The MDS identified R178 required extensive assistance of one staff member to walk in and out of room, locomotion on and off the unit; Supervision and setup with eating. R178 was identified as having no impairment in functional range of motion for his arms or legs. The quarterly MDS dated 6/11/15, indicated cognition had improved to a score of 15	2 545		

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2 545	Continued From page 12 (cognitively intact). R178's ability to walk in room and out of room, locomotion on and off unit had improved to independent without any setup by staff, and eating had improved to independent after set up. R178 was identified as having impairment in functional range of motion on one arm. The medical record lacked evidence of a significant change MDS being completed for the improvements R178 had with ambulation in room and on the unit, eating, and cognition. On 8/5/15, at 2:55 p.m. RN-A reviewed R178's admission and quarterly MDS's and supporting documentation for cognition and activities of daily living and acknowledged R178 should have had a Significant Change MDS completed. RN-A stated she had viewed all locomotion as one change, and with current cognition score now he had two changes. Agreed that it was four different areas on the MDS but practically looked at as one. RN-A verified the clinical record lacked evidence the significant change in status was considered for the quarterly MDS on 6/11/15. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, "A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not 'self-limiting' (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan." In addition, a significant change should be completed for improvement as followed: Improvement in two or more of the following: " - Any improvement in an ADL physical	2 545		

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2 545	Continued From page 13 functioning area where a resident is newly coded as Independent, Supervision, or Limited assistance since last assessment; - Decrease in the number of areas where Behavioral symptoms are coded as being present and/or the frequency of a symptom decreases; - Resident's decision making changes for the better; - Resident's incontinence pattern changes for the better; - Overall improvement of resident's condition." SUGGESTED METHOD OF CORRECTION: The administrator could insure the registered dietitian has time to conduct the comprehensive resident assessments when a significant change in condition occurs. The director of nursing could educate the staff related to the requirements related to comprehensive reassessments. The director of nursing could develop a tool to audit resident records to ensure the appropriate assessments are completed at the time of significant change. These could be reviewed at the quarterly quality assurance meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 545		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by:	21375		9/15/15

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21375	Continued From page 14 Based on observation, interview and document review, the facility failed to ensure staff utilized appropriate hand hygiene during the provision of care for 1 of 3 residents (R250) observed during activities of daily living. Findings include: On 8/5/15, at 8:34 a.m. nursing assistant (NA)-B was observed completing perineal cares with R250. NA-B with gloved hands assisted R250 to do perineal care and attempted to remove R20's soiled incontinent product which R250 refused. NA-B removed her left glove, and without washing her hands or using hand sanitizer, used the facility cell phone to contact another staff member. NA- B then went to the resident's door, removed her right glove, and opened the door to the hallway to look for help. When NA-B closed the door she put on clean gloves and went to R25's bedside to cover R250 with bed linens and make R250 comfortable. NA-B then removed her gloves and exited R250's room. On 8/5/15, at 8:43 a.m. NA-B confirmed she had not washed her hands after glove removal or after leaving R25's room. On 8/5/15, at 8:47 a.m. registered nurse (RN)-B stated during interview that staff are expected to conduct hand hygiene after glove removal, and before and after resident contact. On 8/6/15, at 12:36 p.m. the director of nursing verified the facility protocol was for staff to conduct hand hygiene after removal of gloves. The facility's Hand Hygiene policy dated 5/2013, instructed staff to perform hand hygiene after removing gloves and before and after assisting	21375	Corrected	

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21375	Continued From page 15 residents with personal cares. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revice policies and procedures related to hand hygiene could provide additional staff education. The director of nursing or designee could develop an audit tool to ensure appropriate hand hygiene practices are implemented. provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21375		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure cleanliness and appropriate maintenance to resident rooms for 6 of 18 resident rooms (R79, R114, R189, R139, R223, R399, R69, R178, R183, R310, R354, R357, R385) reviewed for environmental concerns. In addition, the facility failed to ensure dishwashers in 4 of 8 kitchenettes throughout the facility were maintained in a sanitary manner. In addition, the facility failed to ensure the safety disconnection switch for the stove in the cottage area was activated when the stove was not in use. This has the potential to affect 18 of 18 (R40, R57, R59, R87, R139, R283, R310, R225, R128 R340, R352, R227, R107, R192, R4, R72,	21665	Corrected	9/15/15

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21665	Continued From page 16 R4) residents identified by staff as at risk. Findings include: On 8/6/15, from 1:11 p.m. to 1:52 p.m. an environmental tour was conducted. The environmental services director (ESD) and a staff member from physical plant (PP) were present during the tour. During the tour the following environmental concerns were identified and confirmed with the ESD and PP staff member: R79's bathroom wall had an area from the floor up approximately one foot, which had chipped and peeling paint near the doorjamb. The ESD verified the chipped paint area created an uncleanable surface. R114's bathroom wall also had an area from the floor up approximately one foot which was chipped and where paint was peeling and sticky near the doorjamb. The ESD verified the chipped paint area created an uncleanable surface. The PP staff member reported that a plastic guard previously covering the chipped paint must have fallen off. R189's room had black scuff marks on the floor over approximately five feet on the left side of the room. The bathroom doorjambs from the floor up approximately one foot had chipped and peeling paint. The ESD verified that the chipped paint areas were not a cleanable surface and that the scuff marks were not homelike. R139's room had a soiled build up on the carpet. The areas were gray and had a dirty appearance. The ESD reported that the facility was aware of this but the resident would not allow staff to remove her furnishings to clean the floor. Review	21665		

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21665	Continued From page 17 of the resident's record revealed no documentation of such refusals. R223's room had scuffed marks on the floor to the right side of the entry way. There was peeling and chipped paint observed by the bathroom doorjambs from the floor up about one foot. The ESD verified that the chipped paint areas created uncleanable surfaces and that the scuff marks should be cleaned up. R399's room had an area where sheet rock was exposed approximately two feet in diameter on the wall behind the resident's recliner. There was also an area on the left side of the room approximately one foot up the wall where there was missing paint, and there were wheel chair scuff marks. The ESD verified that the exposed sheet rock areas created uncleanable surfaces and that the scuff marks should be cleaned up. During the tour, the PP staff member reported there had been a work order submitted for the repairs, but was not able to supply a copy of the work orders. Additionally during the tour, eight resident's bathroom (R69, R139, R178, R183, R310, R354, R357, R385) vents were observed to be covered with a heavy layer of dust. The PP staff member reported that one time a year their department's staff cleaned the ventilation system and vents, but could not confirm whether the cleaning had been completed yet this year. On 8/6/15, at 1:53 p.m. the ESD and PP staff member reported there was no formal preventative maintenance program for the facility.	21665		

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21665	Continued From page 18 They stated their protocol was for the housekeeper to fill out a form for needed paint/maintenance which they were to give to the ESD. The ESD further stated reports had been difficult for the staff to complete due to English being a second language for many of the staff. The facility's Maintenance Department Work Order Procedure dated 4/1985, indicated work orders would be picked up Monday through Friday at 8:00 a.m. and 1:00 p.m. and work orders not presently being performed, would be kept on the clip boards outside the maintenance office which would allow others not specifically assigned to complete the work orders. On 8/6/15, at 9:23 a.m. a tour of the facility's kitchenettes was conducted with registered dietitian (RD)-B and the following issues were identified: Refrigerators had dried on food splattered on shelves and inner doors. Freezer seals had brown yellow build up in them. Cabinet doors and drawer fronts had sticky areas of built up grime. Floors had brown to black build up at the baseboards. RD-B verified findings kitchenettes were not clean. During observation of the Dorothea, Johnson, Koller and Ferstad units, the dishwashers were noted to have heavy lime build up around the outside of the dishwashers. RD-B verified the findings and stated that staff were supposed to de-lime the dishwashers once a week. During a continous observation on 8/4/15, from 2:28 p.m. to 3:04 p.m. the stove in the Norway unit kitchenette was observed to be unlocked (power on to stove), which had the potential to allow the burners and oven to be turned on by	21665		

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21665	Continued From page 19 any resident in the area. Norway unit: On 8/4/15, at 2:28 p.m. registered dietician (RD)-B was observed to leave the kitchenette on the Norway unit with the stove unlocked. There was an undated sign 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. -2:44 p.m. nursing assistant (NA)-D entered kitchenette reached for something and then left kitchenette with stove unlocked. -2:51 p.m. NA-E entered kitchenette washed hands, walked from the sink, pass the stove and got ice in a styrofoamcup. NA-E then walked back to sink, passing stove and filled cup with water then left the kitchenette at 2:54 p.m. with the stove unlocked. -3:02 p.m. TMA-C enters kitchenette walked past sink and stove. The stove remained unlocked. -3:03 p.m. registered nurse (RN)-H entered kitchenette, when he left the area the stove remained unlocked. -3:04 p.m. TMA-D entered kitchenette and used a key and locked the stove. When interviewed on 8/4/15, at 3:04 p.m. TMA-D stated that usually they cook in the morning but added, "I do not cook. I always come over and check the stove at the start of my shift. We need to keep it off." TMA-D verified he needed to lock the stove off often because "there is a concern for the residents, R72 likes to come into the kitchen." Boss unit: On 8/4/15, at 2:46 p.m. observed the Boss unit was observed to not have the power locked off.	21665		

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21665	Continued From page 20 RD-B was observed to enter the area and stock the kitchenette. - At 3:20 p.m. the Boss unit stove power was still not locked off. NA-F was observed in the kitchenette, but left without checking the stove. During interview on 8/4/15, at 3:59 p.m. NA-F stated that the stove was suppose to be turned off. "I turned it off. I try to check it as much as I can. I probably turn it off three to four times a week. If the burner knob were to get bumped, it might start a fire." Dorthea unit: During tour of Dorthea kitchenette on 8/6/15, at 9:45 a.m. the stove was observed to not have the power locked off. No one was in the kitchenette. At 11:00 a.m. the stove was observed to have been powered off. Auxiliary unit: During a tour of the Auxiliary unit kitchenette on 8/6/15, at 10:35 a..m. the stove was observed to not be locked in the power off position. No one was in the kitchenette. When interviewed on 8/6/15, at 9:10 a.m. RD-B stated "the people that serve the meal turn them (stove) on and then they key them off. Breakfast is the most common time they use the stoves." Resident records were reviewed and the following residents were identified as having severe cognitive impairment. R40's MDS dated 7/16/15, indicated R40 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit. R57's MDS dated 7/15/15, indicated R57 had	21665		

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severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R59's MDS dated 7/1/15, indicated R59 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R87's MDS dated 7/22/15, indicated R87 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R139's MDS dated 7/23/15, indicated R139 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R283 dated 6/9/15, indicated R283 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R310's MDS dated 5/21/15, indicated R310 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R225's MDS dated 5/21/15, indicated R225 had severe cognitive impairment and was able to propel self in wheelchair around the unit.
R128's MDS dated 7/9/15, indicated R128 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R340's MDS dated 6/24/15, indicated R340 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in

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the wheelchair the resident was able to propel the wheelchair around the unit.
R352's MDS dated 6/3/15, indicated R352 had severe cognitive impairment and was able to propel self in wheelchair around the unit. R352 was able to ambulate with a walker around the unit.
R227's MDS dated 6/3/15, indicated R227 had severe cognitive impairment and required assistance to transfer to the wheelchair. Once in the wheelchair the resident was able to propel the wheelchair around the unit.
R107's MDS dated 5/20/15, indicated R107 had severe cognitive impairment and was able to propel their wheelchair around the unit, or walk on the unit with a walker.
R192's MDS dated 6/3/15, indicated R192 had severe cognitive impairment and was able to transfer self into wheelchair and propel their wheelchair around the unit.
R4's MDS dated 6/3/15, indicated R4 was cognitively intact but unit staff identified him as confused, requiring supervision if in kitchen. R4 was able to transfer self into wheelchair and propel wheelchair around the unit. R4 could walk with walker around the unit.
R72's MDS dated 6/18/15, indicated R72 was cognitively intact but unit staff identified him as confused, requiring supervision if in kitchen. R72 was able to transfer self into wheelchair and propel wheelchair around the unit. R72 could walk with walker around the unit.

When interviewed on 8/6/15, at 11:10 a.m. the director of nursing stated "the people in the kitchen are responsible for turning the stove on and off. This may be nursing, housekeeping, assistant administrator. Whoever was cooking is responsible."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00501	A. BUILDING: _____ B. WING _____	08/06/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21665	Continued From page 23 An undated policy titled, A Neighborhood Guide to Cooking, Serving and Storing Food included directions for staff: ... "b. Stove-turn on with key during meals/cooking only! i. If baking cake/cookies and you are preheating the oven--be sure to check and remove pots/pans often stored inside ii. Please KEY OFF STOVE when not in use/after meals!" SUGGESTED METHOD OF CORRECTION: The administrator could review and revise the policies, educate staff and identify trends of environmental safety, cleanliness issues. The administrator could work with the director of nursing (DON) to ensure staff are reporting environmental issues appropriately. Audits could be conducted to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21665		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care	22000		9/15/15

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22000	Continued From page 24 agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their Abuse Prevention	22000	Corrected	

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	00501	A. BUILDING: _____ B. WING _____	08/06/2015

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22000	Continued From page 25 policy regarding screening procedures for 2 of 5 newly employed employees (E1, E2) whose background checks were not verified prior to working with residents. Findings include: The facility's Vulnerable Adult/Abuse Prevention Policy dated 3/2015, indicated all applicants for employment in the facility should, at a minimum, have the following screening check conducted: "a.) Reference checks with the current and/or past employer, b.) Appropriate licensing board or registry check, c.) Criminal Background Check (CBC) pursuant to facility policy or State law... i.) Employees, volunteers and interns may begin work pending the outcome of the CBC, but must be under continuous, direct supervision if they have access to persons receiving services. If the results of the CBC are returned with the employee being ineligible to work in this environment with vulnerable adults, their employment will be terminated immediately." Review of new hire list provided by the facility on 8/6/15 indicated employee (E)-1 had a start date of 3/10/15. Review of the Background Study Clearance had a study date of 6/30/15. Review of the undated Nursing Department schedule for E1 indicated E1's last orientation day was 3/16/15. Review of new hire list provided by the facility on 8/6/15 indicated E2 had a start date of 7/14/15. Review of the Background Study Clearance had a study date of 8/4/15. Review of the undated Nursing Department schedule for E2 indicated E2's last orientation day was 7/22/15. During an interview on 8/6/15, at 8:13 a.m. the director of human resources (DHR) stated E1's	22000		

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22000	Continued From page 26 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.	22000		