

#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 8, 2023

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

RE: CCN: 245347

Cycle Start Date: February 16, 2023

#### Dear Administrator:

On February 16, 2023, a survey was completed at your facility by the Minnesota Department(s) 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 electronically delivered CMS-2567, whereby significant corrections are required.

#### **REMEDIES**

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 7, 2023.
- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 7, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 7, 2023.

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

This Department is also recommending that CMS impose:

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

Lyngblomsten Care Center
March 8, 2023
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only if CMS agrees with our recommendation.

#### NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 7, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lyngblomsten Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 7, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

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

#### ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

#### **DEPARTMENT CONTACT**

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

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Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 16, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

#### **APPEAL RIGHTS**

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to

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file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

#### Steven.Delich@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

#### https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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

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

William Abderhalden, Fire Safety Supervisor Deputy State Fire Marshal Health Care/Corrections Supervisor – Interim Minnesota Department of Public Safety 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145

Cell: (507) 361-6204

Email: william.abderhalden@state.mn.us

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us

(X1) PROVIDER/SUPPLIER/CLIA

**IDENTIFICATION NUMBER:** 

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

PRINTED: 03/26/2023 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED

AND PLAN O	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG		VIPLETED
		245347	B. WING		02	C / <b>16/2023</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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	survey was conduction was all was NOT in compliant	B, a standard recertification ted at your facility. A complaint so conducted. Your facility ance with the requirements of art B, Requirements for Long S.				
	In addition to the refollowing complaints	certification survey, the swere reviewed				
		0085747), 0087959), and				
		laints were reviewed: 0090860) with a deficiency F610.				
	, .	f correction (POC) will serve f compliance upon the				
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE		(X6) DATE
Electron	ically Signed					03/15/2023

(X2) MULTIPLE CONSTRUCTION

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.

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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	enrolled in ePOC, y at the bottom of the form. Your electronic be used as verificate Upon receipt of an onsite revisit of you validate that substate regulations has been Reporting of Allege CFR(s): 483.12(b)(s	acceptable electronic POC, an r facility may be conducted to ntial compliance with the en attained. d Violations 5)(i)(A)(B)(c)(1)(4)	F6	609		3/24/23
	neglect, exploitation must:  §483.12(c)(1) Ensurinvolving abuse, nemistreatment, include source and misapp	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2				
	that cause the allegations bodily injury the events that cause abuse and do not retain the administrator of officials (including the adult protective serior jurisdiction in lorest	gation is made, if the events pation involve abuse or result in a continuous pation and the set of the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides and the state of the state of the state state law provides and the state of th				
	designated represe	ort the results of all e administrator or his or her ntative and to other officials in ate law, including to the State				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 609	incident, and if the appropriate correct This REQUIREMED by: Based on interview facility failed to immadministrator and moderate Agency (SA), established policies allegation of reside residents (R27, R1 allegations of abuse Findings include:  R27's diagnoses resincluded dementia, one side of the bod or inability to move following cardiovas right dominant side R27's quarterly Minassessment dated cognitively intact, hearing, clear speed understand. R27 resone staff for most A and did not walk.  R27's care plan creating the resident of the policies allegation of reside residents. R27's quarterly Minassessment dated cognitively intact, hearing, clear speed understand. R27 resone staff for most A and did not walk.	hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced and document review, the nediately report to the no later than 2 hours, to the in accordance with and procedures, and resident verbal abuse and an int to resident abuse for 2 of 2 92) who was reviewed for e.  Peport printed on 2/15/23, and hemiplegia (paralysis on by) and hemiparesis (weakness on one side of the body) cular disease affecting his immum Data Set (MDS) 11/20/22, indicated R27 was ad adequate vision and ech, was understood and could equired extensive assistance of ADL's (activities of daily living) eated on 8/12/22, indicated on in ability to remove self temiplegia and hemiparesis of trebral infarction (stroke).		The preparation of the follocorrection for this deficiency constitute and should not be as an admission nor an agrescility of the truth of the factonclusions set forth in the deficiency. The plan of corresprepared for this deficiency solely because it is required of State and Federal law. We the foregoing statement, the that:  F609 It is the policy of Lyngbloms alleged violations involving a neglect, exploitation or mist including injuries of unknown misappropriation of resident reported immediately, but no hours after the allegation is events that cause the allegation abuse or serious bodily injurtan 24 hours if the events allegation do not involve abuse or serious bodily injurtadministrator of the facility and officials. To assure continuent the following plan has been Regarding cited residents: With respect to resident R2 referenced was reported by	y does not e interpreted eement by the ets alleged on statement of ection was executed by provisions ithout waiving e facility states et that all abuse, reatment, in source and to property are ot later than 2 made, if the etion involve ry, or not later that cause the use and do not y, to the end to other ed compliance implemented:  7, the incident rursing		
	Progress notes in F (FMR) indicated:	R27's electronic medical record		administration when addition was reported by the state su			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMF	SURVEY
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F 609	services (SS)-A: Nursing assistant (member (FM)-C ju R162 - "threatened FM-C had left. Writer 162 told him he win the face". Writer this and R27 said to because they both much noise. Writer past and both have R162 also threaten roommate R162 will R27 but did not face and only threat would not actually "verbally aggressive." Writer or fearful to which asked if he felt safe his roommate this He stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated that if Rawould stomp on his and house supervisorom waiting list. Stated has a list of the list of t	NA)-C told writer that family st told her R27's roommate, him" while she was visiting. ter spoke with R27. R27 stated would "kill him" and "punch him asked R27 what precipitated hey do not like each other think the other one makes too has offered ear plugs in the edeclined. R27 then stated hed FM-C. Writer spoke with ho stated he did say he would say he would punch him the atened R27. R162 stated he harm R27 and that he is the but not physically asked R27 if he was scared he answered "no". Writer the staying in the same room as weekend and he stated he did. 162 were to punch him, he is foot in return. Nurse on shift sor notified. R27 is on private is to continue to assist PRN	F 6	2-13-23. Resident R27 was different room and neighborh assessed by the house psyc psychosocial harm and found distressed and comfortable i room. Results of internal invalidations as R27 endo threatened to the state surverespect to R192, the resident assessed for harm following rough treatment and verbal astaff. Resident reported that treatment and verbal abuse witnessed by two staff memorister with both staff menot support residents report. has been observed and has demonstrated any changes to or behavior that indicates eff allegation. Resident care plaupdated to reflect approache preferred caregivers to prevent occurrences. Resident is so transfer to long term care se building. Actions taken to identify other residents having similar occurvations taken to identify other residents having similar occurvations.	hologist for d to be not n his new restigation esident to rsed feeling eyor. With t was her reports of abuse by the rough was pers, mbers does Resident not to her mood ects from the an has been es and ent future heduled to ction of the er potential arrences: quirements appropriate g compliance g nication, process for all use or neglect equiring	

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F 609	During an interview stated, "I have a terup all night." R27 styelled and screame R27 then stated R1 saying "I'll get you twas contacted via thad been at the factivisiting R27. FM-C the room when she arrive to the room, described by FM-C made her jump. WI out loud that R162 seemed to set off R162 walked to R2 both FM-C and R27 SOB (son of a bitch R162 had been so going to throw urine the raised voices, nwas going on. FM-C R27 names including could just kill you." stomach," adding it stated she was very her way out of the fp.m. talked to a nurname she did not k R162 had been very R162 had said to he oh they do this. FM R162 was not jokin both her and R27, i very upsetting. With concluded, R27 stawitnessed this behavious her name. W	rible roommate, he keeps me tated his roommate, R162, ed due to his sore diabetic foot. 62 had threatened FM-C, oo." From R27's room, FM-C telephone. FM-C stated she tility the afternoon of 2/10/23, stated R162 had not been in arrived. When R162 did he made loud sounds - as involuntary sounds that hen that happened, R27 said did that all the time, which R162. With a urinal in hand, 7's side of the room where were sitting and stated, "you in) I could kill you." FM-C stated angry she thought he was e at them. FM-C stated despite to staff came in to see what C stated R162 called her and ing boar head and stated, "I FM-C stated, "I felt sick to my was so unexpected. FM-C yoconcerned about R27 and on facility at approximately 3:15 rsing assistant (NA) whose now. FM-C told the NA that you psetting and told her what her and R27. The NA replied, -C stated she told the NA, that g; that he had been abusive to informing the NA it had been in telephone call to FM-C atted one of the aids had avior in the past, but did not hen asked how this incident of stated he supposed R162	F 60	Measures put in place to enspractice does not occur: Facility reviewed the VA policy guidance for reporting and in no revisions were made, how secondary process was development, and potential abuse and neglect Utilizing the facility online leaseducation was developed the reporting requirements for expective responsibilities.  Effective implementation of a monitored by: Nursing Administration will reallegations of abuse, neglect or mistreatment for proper reallegations of abuse, neglect or mistreatment for proper reallegations and administration will completing 3 audits per weethen 1 audit per week for 2 responsible to maintain will be: The Director of Nursing and will audit the data collected was presented and discussed may always a surance Committee At that time the Quality Assurance Committee At that time the Quality Assurance Committee will make the decision/recommendation renecessary follow-up studies Completion date for certificationly is 3-24-23	cy and facility nvestigations, wever a eloped to all elegations. Arning portal, at reviews the ach staffs' actions will be eview all t, exploitation eporting. Onduct f nursing staff, k for 1 month, months. Director of ain compliance of which will be entitly at the elementings. Irrance egarding any or actions.		

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F 609	had to, he could hit pointing to his orthostated he had to ke around R162 so R1 On 2/13/23, at 3:16 (DON) office, both (ADON)-D where in allegation of verbal FM-C.  On 2/13/23, at 3:27 been informed of the registered nurse (RThe DON stated heresulted from the verbally aggree but would never hawas not afraid of R stated he felt R27 in the State surveyor.  On 2/13/23, at 4:37 surveyor that the in the SA, adding here facility information to During an interview SS-A stated NA-C in 2/10/22, in the "SS-A that R27 and that R162 said som SS-A stated she the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in their reverything was going the state of the separately in the separately	snuck up on him, adding if he R162 with his pick-up stick, opedic reacher-grabber. R27 ep his mouth shut when 162 didn't start yelling at him.  In p.m., in the director of nursing the DON and assistant pon.  In p.m., the DON stated he had be incident via telephone by and altercation, therefore the en reported to the SA. The and admitted to staff he had assive toward R27 and FM-C, and R27. R27 had told SS-A he and felt safe. The DON and dramatized the incident for a p.m., the DON informed cident would be reported to a felt the surveyor had given the and talked to her after incident and talked to her after incident and talked to her after incident and talked to R27 and R162 were not getting along; and talked to R27 and R162 oom. When she asked R27 if and okay, R27 replied that R162 e basement with the rats. R27		09		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING	i	02	C / <b>16/2023</b>
	PROVIDER OR SUPPLIER	ΓER		STREET ADDRESS, CITY, STATE, ZIP CO  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	<u> </u>	, ioizozo
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 609	punch you in he fact the incident, R27 to along and that R162 both residents had past. Following the SS-A informed RN-FM-C and the DON her he felt safe, was comfortable staying on R162's foot if R1 residents had not buring an interview NA-C stated FM-C complaining that R1 she felt R162 had buring that R162 said NA-C that R162 said NA-C said she told around a lot, that R1 FM-C she would let she informed both I (LPN)-B and SS-A wasked if she had he past, NA-C stated to	R162 said, I will kill you and the. When asked what caused ld SS-A, the two did not get 2 was too loud. SS-A stated been offered ear plugs in the interview with R27 and R162, E who stated she would call . SS-A stated since R27 told is not scared or fearful, was in his room and would stomp 62 came after him, the two een separated.  on 2/14/23, at 3:00 p.m., had come to her on 2/10/23, l62 and R27 argued a lot and leen bullying R27. FM-C told do he was going to kill R27. FM-C that the two men joked l62 didn't mean it, and told the nurse know. NA-C stated itensed practical nurse what FM-C told her. When leard the two men argue in the he two interacted a lot with had not heard them		609		
	a.m., LPN-B stated the incident on 2/10 R162 separately. Be LPN-B about the not told her what happed therethat R162 the asked if R27 and R altercations in the pubig, no threats. LPN	interview on 2/15/23, at 10:49 when NA-C informed her of 2/23, she spoke to R27 and oth residents complained to sises each other made. R27 ened when FM-C was reatened to kill them. When 162 had gotten into east, LPN-B stated, nothing I-B stated R162 who was new ing to adjust to R27 and R27				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	245347	B. WING			/16/2023	
NAME OF PROVIDER OR SUPPLIE		14	REET ADDRESS, CITY, STATE, ZIP CODE  15 ALMOND AVENUE  INT PAUL, MN 55108			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
spoke to SS-A when RN-E know about RN-E who on dutives not available. During an intervie DON stated he reaccurate information and intent. The Didecision (not to reinformation he restated he consider personalities of reand while R162 minever acted on the During an intervier administrator state 2/10/23, incident had been reported 2/13/23. The administrator state 2/13/23 and should have been time frame outlined reporting allegations attend the commens should have been better to err on the report with the SA R192.  R192's significant (MDS) assessment had diagnosis who deficiency of red (A-fib) (a heart conflow as well as it is	est to R162. LPN-B stated she no informed her she would let to the incident.  If y on 2/10/23, the evening shift, for interview.  If w on 2/16/23 at 10:05 a.m., the elied on staff to provide him with tion in order to assess risk, harm ON stated he still made the right eport to the SA) based upon the ceived on 2/10/23. The DON ered the dynamics and esidents when making decisions hade outrageous comments, he tem and R27 stated he felt safe.  If w on 2/16/23, at 11:00 a.m., the red she first learned of the between R27 and R162 when it d by the State surveyor on hinistrator stated the incident in reported to the SA within the red in the facility policy on one of abuse. The administrator ents made by R162 to R27 in taken seriously; that it would be re side of caution and file a					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED
245347	B. WING	02/16/2023
NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER	STREET ADDRESS, CITY, STATE, Z  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 PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLÉTION THE APPROPRIATE DATE
Continued From page 8 assistance with activities of daily living (ADL's which included bed mobility, transfers, and toileting.  R192's care plan revised 1/6/23, revealed R1 had an alteration in ability to remove self from harm related to nursing home placement. The care plan directed staff to anticipate R192's needs and remove R192 from any potential harmful situations.  During an interview on 2/14/23, at 5:02 p.m. R stated a few weeks ago in the evening during cares nursing assistant (NA)-A became angry cursed when he had to change R192's incontinent product. R192 stated when he turn her, he was rough and she was scared. R192 stated she had reported her concerns to the director of nursing (DON) and the DON told he NA-A would no longer work with her.  Review of facility reported incidents to the SA lacked documentation of the SA being notified the allegation of abuse.  During an interview on 2/15/23, at 8:17 a.m. NA-A stated on 2/6/23, registered nurse (RN)-had told him he was not allowed to work with R192 anymore because R192 had alleged the NA-A had been rough during cares.  During an interview on 2/15/23 at 8:45 a.m. R stated on 2/5/23, RN-B had told him that R192 reported NA-A had been rough with her during cares. RN-A further stated he had not talked v R192 or reported the allegation of abuse to the SA because he thought it had already been	92 and ned er l of B at N-A 2 3 vith	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING	<b>}</b>	02	C / <b>16/2023</b>
	PROVIDER OR SUPPLIER		<u>I</u>	STREET ADDRESS, CITY, STATE, ZIP COI  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	<u> </u>	110/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 609	RN-B stated on 2/5 had stated NA-A had cares within the past then talked with R1 had been rough with stated she had reported the DON and later to told NA-A he was not R192. RN-B confirmal allegation of abuse abuse in report on 2 she had not directly the allegation of abuse in reported the reported	on 2/15/23, at 2:30 p.m. /23, RN-C had told her R192 ad been rough with her during st few days. RN B stated she 92 who had confirmed NA-A h her during cares. RN-B orted the allegation of abuse to that day or the next day RN-B to longer allowed to work with med she had not reported the to the SA.  on 2/15/23, at 3:03 p.m. ad heard of the allegation of 2/4/23. RN-C further stated or talked with R192 regarding use. RN-C confirmed she had egation of abuse to the SA.  on 2/15/23, at 3:08 p.m. urse (LPN)-A stated on 2/4/23, hat NA-A became angry and the came in to change R192's and the R192 further stated she was A-A was still working on her and she had not reported the		609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´´	TIPLE CONSTRUCTION DING	(X	(3) DATE SURVEY COMPLETED
		245347	B. WING	i 		C <b>02/16/2023</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIA	D 4TE
F 609	had been an allegate would have been to immediately but not forming the suspice. Facility policy titled Prevention with revente facility would not including verbal about willful, meaning the deliberately. Verback harm or any repeat that willfully included derogatory terms to within their hearing ability to comprehe violation had been Administrator, DOI immediately report the identified residinvestigation of the situations, the facility occurrence to detend investigation of an "all violation is a situated observed or report visitor or others but and, if verified, courselved or report visitor or others but and, if verified, courselved or report visitor or others but and, if verified, courselved or report visitor or others but and, if verified, courselved or report visitor or others but and, if verified, courselved or report visitor or others but and, if verified, courselved or report visitor or others but and, if verified, courselved or report visitor or others but and, if verified, courselved or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others but and it violation is a situated observed or report visitor or others.	is a reportable event but if it ation of abuse his expectation hat it would have been reported of more than two hours after ion of abuse.  I Vulnerable Adult / Abuse vised date of 3/2022, indicated of tolerate any forms of abuse, buse. Abuse was defined as a individual would have acted all Abuse referred to threats of ted or malicious oral language and disparaging, humiliating and to residents or their families, or a distance, regardless of age, and, or disability. If an alleged identified and reported to the N, or designee, the facility must at it and provide protection for ent(s) prior to conducting the entity may initially evaluate an ermine whether it meets the eged violation." Alleged ion or occurrence that is seed by staff, resident, relative, at has not yet been investigated all be noncompliance with the ints related to abuse. The N, or designee would a suspected abuse to the ocal agencies according to the eporting to State Agencies and	F 6	509		

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING _			C 16/2023	
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108			
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F 609	where the following 1. The act was "willt actions were delibe individual intended i individual with cogn a willful act). 2. There was "harm the infliction of injuri intimidation or punis mental anguish.  Facility policy titled Altercation with revi it was the policy of t residents/individuals environment for all i Resident to resident an incident involving inflicts injury, unreas intimidation, or puni harm, pain or mental resident. Willful was action was deliberat accidental), regardle intended to inflict injudefined as resultant anguish. The facility interventions that ac negative interaction eliminating or reduct distressed behavior	two criteria were met: ful" meaning the individual 's rate regardless of whether the to inflict injury or harm (an itive impairment, can commit ", meaning the act resulted in y, unreasonable confinement, shment causing injury, pain, or  Resident to Resident sed date of 10/2019, indicated he facility to protect s and to maintain a safe living individuals residing there. It altercation was defined as g a resident who willfully sonable confinement, shment with resulting physical al anguish upon another sed defined as the individuals te (not inadvertent or tess of whether the individual fury or harm. Injury was to physical harm, pain or mental to would implement ddressed potential or actual s. Examples included fing underlying causes of the such as boredom or pain, mental influences such as	F 60	09			
	Investigate/Preventa CFR(s): 483.12(c)(2	Correct Alleged Violation	F6	10		3/24/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245347	B. WING			C <b>16/2023</b>
	PROVIDER OR SUPPLIER  OMSTEN CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CO 1415 ALMOND AVENUE SAINT PAUL, MN 55108	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 610	§483.12(c)(2) Have violations are thoro §483.12(c)(3) Preveneglect, exploitation investigation is in p §483.12(c)(4) Repoint estigations to the designated represe accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMED by:  Based on interview facility failed to comfor a resident to residents were safe abuse by allowing the continue to have accordance to have accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMED by:  Based on interview facility failed to comfor a resident to residents were safe abuse by allowing the continue to have accordance with St Survey Agency, with incidents were safe abuse by allowing the continue to have accordance with St Survey Agency, with incidents were safe abuse by allowing to continue to have accordance with St Survey Agency, with incidents were safe abuse by allowing to continue to have accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMED by:  Based on interview facility failed to comfor a resident to resident to residents were safe abuse by allowing to continue to have accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMED by:  Based on interview facility failed to comfor a resident to	e evidence that all alleged ughly investigated.  ent further potential abuse, in, or mistreatment while the rogress.  ort the results of all e administrator or his or her entative and to other officials in rate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced or and document review, the applete a thorough investigation sident altercation and to assure and prevent further potential the alleged perpetrator (AP) to excess to other vulnerable allegation of abuse, for 2 of 2 allegation of abuse, for 2 of 2 allegation of abuse.  Export printed on 2/15/23, and hemiplegia (paralysis on allegation) of the body) cular disease affecting his		The preparation of the follow correction for this deficiency constitute and should not be as an admission nor an agrefacility of the truth of the fact conclusions set forth in the state deficiency. The plan of correprepared for this deficiency solely because it is required of State and Federal law. Withe foregoing statement, the that:  F610 It is the policy of Lyngblomst facility responds to allegation exploitation, or mistreatment conducting a thorough investigation or mistreatment conducting any further potential process.	does not interpreted ement by the salleged on statement of ection was executed by provisions ithout waiving facility states en that the as of neglect, toy; tigation, tial abuse,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	-	
LVNCDI		TED		1415 ALMOND AVENUE		
LYNGBL	OMSTEN CARE CEN	IER		SAINT PAUL, MN 55108		
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F 610	Continued From pa	nae 13	F 6	310		
1 010	_					
	,	ad adequate vision and		the investigations is in progre	•	
		ch, was understood and could		all investigative results are re	•	
		equired extensive assistance of ADL's (activities of daily living)		Administrator or their design officials according to state la	•	
	and did not walk.	ADLS (activities of daily living)		the State Survey Agency, wit	,	
	and did not waik.			days of the incident, and take	•	
	R27's care plan cre	eated on 8/12/22, indicated		appropriate corrective action		
	<b>.</b>	on in ability to remove self		To assure continued complia	•	
		emiplegia and hemiparesis of		following plan has been impl		
		rebral infarction (stroke).		Regarding cited residents:		
				With respect to resident R27	', the incident	
	Progress notes in F	R27's electronic medical record		referenced was reported by		
	(EMR) indicated:			administration when addition		
	2/10/2023, at 5:35 p.m., note entered by social			was reported by the state su	•	
	services (SS)-A:	NIAN A talal accessita en Ala a t. Canacilla e		2-13-23. Resident R27 was		
		NA)-C told writer that family		different room and neighborh		
	, , ,	st told her R27's roommate, him" while she was visiting.		assessed by the house psychosocial harm and found		
		er spoke with R27. R27 stated		distressed and comfortable i		
		ould "kill him" and "punch him		room. Results of internal inv		
		asked R27 what precipitated		substantiated allegation of re	•	
		hey do not like each other		resident abuse as R27 endo		
		think the other one makes too		threatened to the state surve	•	
		has offered ear plugs in the		respect to R192, the residen	t was	
	past and both have	declined. R27 then stated		assessed for harm following	her reports of	
		ed FM-C. Writer spoke with		rough treatment and verbal a	•	
		no stated he did say he would		staff. Resident reported that	•	
		say he would punch him the		treatment and verbal abuse		
	_	tened R27. R162 stated he		witnessed by two staff memb	•	
	_	narm R27 and that he is		interviews with both staff me		
	, ,	e but not physically asked R27 if he was scared		not support residents report. has been observed and has		
		ne answered "no". Writer		demonstrated any changes t		
		e staying in the same room as		or behavior that indicates eff		
		weekend and he stated he did.		allegation. Resident care pla		
		62 were to punch him, he		updated to reflect approache		
		foot in return. Nurse on shift		preferred caregivers to preven		
	-	sor notified. R27 is on private		occurrences. Resident is sc		
	_ <b>-</b>	S to continue to assist PRN		transfer to long term care se		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			X3) DATE SURVEY COMPLETED	
		245347	B. WING			C 16/2023
NAME OF F	PROVIDER OR SUPPLIER	_ 100 11	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	10/2023
				1415 ALMOND AVENUE		
LYNGBL	OMSTEN CARE CEN	TER		SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	Continued From pa	ige 14	F 6	10		
	(as needed).			building.		
	(as needed).			Actions taken to identify other	er potential	
	2/10/2023, at 6:37	p.m., note entered by		residents having similar occ	•	
	licensed practice no			Vulnerable adult investigatin		
	R27 reported to SS	-A that roommate R162		protection requirements hav	e been	
		shift. R27 stated that they		reviewed with all appropriate	•	
		the past about noise and the		staff demonstrating complian		
		27 told this writer, he spoke to		respective investigating and	•	
		oing noise issue and was waiting list for a room. Will		responsibilities. Facility adm has implemented a commun		
		the roommates per facility		documentation, and review	•	
	protocol.	the roominates per lacinty		potential vulnerable adult ab		
	protocon.			allegations to ensure those	•	
	During an interview	on 2/13/23, 2:48 p.m., R27		reporting and investigations	. •	
	stated, "I have a ter	rrible roommate, he keeps me		done so appropriately and n	ecessary	
		tated his roommate, R162,		protections are implemented		
		ed due to his sore diabetic foot.		Measures put in place to en	sure deficient	
		62 had threatened FM-C,		practice does not occur:		
		oo." From R27's room, FM-C		Facility reviewed the VA police	•	
		elephone. FM-C stated she ility the afternoon of 2/10/23,		guidance for reporting, investored protections, no revisions we	•	
		stated R162 had not been in		however a secondary proces	,	
		arrived. When R162 did		developed to communicate,		
		he made loud sounds -		and review all potential abus	,	
		as involuntary sounds that		allegations. Utilizing the fac	•	
	,	hen that happened, R27 said		learning portal, education wa	•	
		did that all the time, which		that reviews the reporting, in	vestigating	
		R162. With a urinal in hand,		and protection requirements		
		7's side of the room where		staffs' respective responsibil		
		7 were sitting and stated, "You		Effective implementation of	actions will be	
	<b>\</b>	n) I could kill you." FM-C stated		monitored by: Nursing Administration will re	oviow all	
		angry she thought he was at them. FM-C stated despite		Nursing Administration will reallegations of abuse, neglect		
		no staff came in to see what		or mistreatment for proper in	, I	
	· ·	C stated R162 called her and		and protection. Nursing Adr	•	
		ng boar head and stated, "I		will conduct random knowled		
		FM-C stated, "I felt sick to my		nursing staff, completing 3 a	•	
		was so unexpected. FM-C		week for 1 month, then 1 au	•	
		y concerned about R27 and on		for 2 months. Findings will be	•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	l \ /	(X3) DATE SURVEY COMPLETED	
		245347	B. WING			C 16/2023	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	10/2020	
LYNGBL	OMSTEN CARE CEN	ITER		1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORX  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 610	p.m. talked to a numame she did not R162 had been verented to had said to he oh they do this. FN R162 was not jokin both her and R27, very upsetting. With concluded, R27 st witnessed this behand to, he could him feel, R2 could hurt him if he had to, he could him pointing to his orth stated he had to ke around R162 so R On 2/13/23, at 3:2 been informed of to (RN)-E on 2/10/23 admitted neither he interviewed FM-C since R162 had according aggressive DON stated he did to interview witnessince R27 was coold describe what took On 2/13/23, at 4:3 surveyor that R27 different room and an interview.  During an interview.  During an interview.	facility at approximately 3:15 ursing assistant (NA), whose know. FM-C told the NA that ary upsetting and told her what her and R27. The NA replied, M-C stated she told the NA that her; that he had been abusive to informing the NA it had been the telephone call to FM-C ated one of the aids had havior in the past, but did not When asked how this incident to reacher years and the supposed R162 he snuck up on him, adding if he it R162 with his pick up stick, hopedic reacher-grabber. R27 heep his mouth shut when 162 didn't start yelling at him.  7 p.m., the DON stated he had he incident by registered nurse, at 5:04 p.m. The DON he nor anyone else had who had witnessed the incident dmitted to staff he had been he toward R27 and FM-C. The I not feel it had been necessary is FM-C about the incident gnitively intact and could		Director of Nursing and Adn Those responsible to mainta will be: The Director of Nursing and will audit the data collected presented and discussed m Quality Assurance Committ At that time the Quality Assurante will make the decision/recommendation macessary follow-up studies Completion date for certificationly is 3-24-23	d/or designee which will be nonthly at the ee meetings. urance egarding any or actions.		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION  ING	` '	TE SURVEY MPLETED
		245347	B. WING		02	C / <b>16/2023</b>
	PROVIDER OR SUPPLIER	ΓER		STREET ADDRESS, CITY, STATE, ZIP C  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 610	along; that R162 satupset him. SS-A state and R162 separate interviews, SS-A inf (RN)-E who stated stated since R27 to scared or fearful, who room, the two resides During an interview NA-C stated FM-C complaining that R162 had been that R162 said he who said she told FM-C around a lot, that R162 said he who said she told FM-C around a lot, that R162 said he who said she informed (LPN)-B and SS-A who saked if she had he past, NA-C stated the each other, but she arguejust joke around a lot, that R162 said he who said she informed (LPN)-B and SS-A who saked if she had he past, NA-C stated the each other, but she arguejust joke around a lot, that R162 said he who said she informed (LPN)-B and SS-A who saked if she had he past, NA-C stated the each other, but she arguejust joke around a lot, that R162 said he who said she informed that R162 said he who said she informed that R162 said he who said she informed that R162 said he who said she told FM-C stated the stated she informed that R162 said he who said she told FM-C stated that R162 said he who said she told FM-C stated that R162 said he who said she told FM-C stated that R162 said he who said she told FM-C stated that R162 said he who said she told FM-C stated that R162 said he who said she told FM-C stated that R162 said he who said she told FM-C stated that R162 said he who said she told FM-C stated that R162 said he who said she told FM-C she would let stated she informed (LPN)-B stated she informed (LPN)-B stated she informed (LPN)-B stated she said she informed (LPN)-B stated she informed (LPN)-B stated she said she informed (LPN)-B stated she informed (LPN)-B st	and R162 were not getting and something to R27 that ated she then talked to R27 ly in their room. Following the formed registered nurse she would call FM-C. SS-A and her he felt safe, was not as comfortable staying in his ents had not been separated.  If on 2/14/23, at 3:00 p.m., had come to her on 2/10/23, 162 and R27 argued a lot and bullying R27. FM-C told NA-C was going to kill R27. NA-C that the two men joked 162 didn't mean it, and told at the supervisor know. NA-C diboth licensed practical nurse what FM-C told her. When eard the two men argue in the he two interacted a lot with had not heard them bund.  Interview on 2/15/23, at 10:49 when informed of the incident oke to R27 and R162 who he noises each other made. Spoke to the residents of the incident of the two the residents of the two then that R162 threatened to kill of the residents had not been seen as a constant of the incident of the residents had not been that R162 threatened to kill of the residents had not been seen as a constant of th		310		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING		02	C / <b>16/2023</b>
	IDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP C 1415 ALMOND AVENUE SAINT PAUL, MN 55108	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		I SHOULD BE	(X5) COMPLETION DATE
thre With and emporing the condition of the condition of the care has white to be asset to be a set to	tness FM-C had a R162 had not be ployees with poinduct between Reviewed. In add en assessed to continue an interview in a serie need verbal and a sessed to continue and a sessed to number and a sessed to remove a sessed to remove and a sessed to remove a sessed to sessed to sessed to remove a sessed to sessed	or by R162 towards R27. In not been interviewed, R27 Deen separated, and Itential knowledge of the R27 and R162 had not been Ition, other residents had not Idetermine if others had I abuse by R162. If on 2/16/23, at 11:00 a.m., the Dowledged that once the facility Ivare of the incident on 2/10/23, Dould have been conducted as Dolicy to ensure the safety of  Change Minimum Data Set It dated 1/7/23, identified R192 In included anemia (a Dood cells) and atrial fibrillation Indition where blood doesn't Dould). MDS indicated R192 In and required extensive Individually living (ADL's) I mobility, transfers, and  Revised 1/6/23, revealed R192 In ability to remove self from Tesing home placement. The Destaff to anticipate R192's The second residual		510		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	TIPLE CONSTRUCTION DING	I` '	TE SURVEY MPLETED
		245347	B. WING	i	02	C / <b>16/2023</b>
	PROVIDER OR SUPPLIER	ΓER		STREET ADDRESS, CITY, STATE, ZIP C 1415 ALMOND AVENUE SAINT PAUL, MN 55108	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		I SHOULD BE	(X5) COMPLETION DATE
F 610	and she was scared reported her concer (DON) a few days I had informed her Nother.  Review of facility relacked documentate being submitted to a confirmed he continued after the allegation.  During an interview registered nurse (Rallowed to continue after the allegation.  During an interview RN-B at confirmed working with other rabuse had occurred.  During an interview RN-C confirmed Naworking with other rabuse had occurred.  During an interview RN-C confirmed Naworking with other rabuse had occurred.  During an interview RN-C said she was still working on her During an interview licensed practical in R192 said she was still working on her During an interview DON confirmed NAWON confirmed NAWO	NA-A turned her he was rough d. R192 stated she had rns to the director of nursing ater. R192 further stated DON IA-A would no longer work with ported incidents to the SA ion of an investigation report the SA.  On 2/15/23, at 8:17 a.m. NA-A nued to work with other allegation of abuse had  On 2/15/23, at 8:45 a.m. N-A) confirmed NA-A was working with other residents of abuse had occurred.  On 2/15/23, at 2:30 p.m. NA-A was allowed to continue residents after the allegation of d.  On 2/15/23, at 3:03 p.m. A-A was allowed to continue residents after the allegation of d.  On 2/15/23, at 3:08 p.m. urse (LPN)-A stated on 2/4/23, scared because NA-A was		510		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			X3) DATE SURVEY COMPLETED	
		245347	B. WING		02	C / <b>16/2023</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1415 ALMOND AVENUE SAINT PAUL, MN 55108	<u> </u>	1012023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE	
F 610	Facility policy titled Prevention with rev a vulnerable adult is completed for all su concerns and turne or designee. While interview the involvif appropriate, neight as appropriate, neight as appropriate, and information to share have them provide observations of interview the safe of the allege such as appropriate representative, alle Conduct a record representative, alle Conduct a record representative, alle Conduct a record representative alleges such as progress in Facility policy titled Altercation with revitant are protected from the time of the incident to the incid	I stated if he had suspected ould have been removed from a the investigation.  Vulnerable Adult / Abuse ised date of 3/2022, indicated investigation would be ispected abuse/neglect indicated investigating the incident, ed resident, family member(s) inborhood interdisciplinary staff any others who may have in a written statement. Conduct is actions and relationships he alleged victim and/or other is actions/relationships between isidents. Conduct interviews in the alleged victim and interviews in the alleged victim and indicated dent altercation, as appropriate, otes.  Resident to Resident is appropriate, otes.  Interview witnesses to be individual(s) other potential altercations at lent. Interview witnesses to be enting behaviors and incident. Document the		510			
	of the parties involv	dent/Accident Report for each red, including a physical the parties involved.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245347	B. WING		02/16	/2023	
	PROVIDER OR SUPPLIER  OMSTEN CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	, , , ,		
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	S483.21(b) Compres \$483.21(b)(1) The implement a compression resident rights set in \$483.10(c)(3), that objectives and times medical, nursing, an eeds that are ident assessment. The conferment in the resident system of maintain the resident system of maintain the resident system of the services that under \$483.24, \$48 provided due to the under \$483.24, \$48 provided due to the under \$483.10, includer \$483.	chensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial rified in the comprehensive comprehensive care plan must and and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required as.25 or §483.40 but are not a resident's exercise of rights and the right to refuse as.10(c)(6).  I services or specialized resident's medical record. The facility disagrees with the ARR, it must indicate its dent's medical record. The facility disagrees with the ARR, it must indicate its dent's medical record. The facility disagrees with the tative(s)- goals for admission and coreference and potential for acilities must document and the sessed and any referrals to	F 656		3/	24/23	

F 656 Continued From page 21 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive person-centered care plan which included care for an indwelling Foley catheter for 1 of 2 resident (R199) reviewed for catheter care. Findings include:  R199's facility admission record dated 12/26/23, indicated R199 was admitted on 12/26/23, with diagnosis which included sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), and bacteremia (bacteria in the blood). Admission record further indicated R199 had an indwelling Foley catheter related to urinary retention.  R199's admission Minimum Data Set (MDS) assessment dated 1/10/23, indicated R199 was	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	` ′	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
LYNGBLOMSTEN CARE CENTER    CAH DEPRICE   CAN DEPRICE   CA			245347	B. WING			
F 656  Continued From page 21 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §448.2.1(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:  Based on document review and interview, the facility failed to develop a comprehensive person-centered care plan which included care for an indwelling Foley catheter for 1 of 2 resident (R199) reviewed for catheter care.  Findings include:  R199's facility admission record dated 12/26/23, indicated R199 was admitted on 12/26/23, with diagnosis which included sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), and bacteremia (bacteria in the blood). Admission record further indicated R199 had an indwelling Foley catheter related to urinary retention.  R199's admission Minimum Data Set (MDS) assessment dated 1/10/23, indicated R199 was			TER		1415 ALMOND AVENUE	ODE	
plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive person-centered care plan which included care for an indwelling Foley catheter for 1 of 2 resident (R199) reviewed for catheter care.  Findings include:  R199's facility admission record dated 12/26/23, indicated R199 was admitted on 12/26/23, with diagnosis which included sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood), and bacteremia (bacteria in the blood). Admission record further indicated R199 had an indwelling Foley catheter related to urinary retention.  R199's admission Minimum Data Set (MDS) assessment dated 1/10/23, indicated R199 was	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	χ (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
cognitively intact and had an indwelling Foley catheter.  Care Area Assessment (CAA) dated 1/12/23, indicated R199 had an indwelling Foley catheter related to urinary retention.  R199's care plan dated 1/5/23, lacked mention of an indwelling Foley catheter and lacked interventions to care for an indwelling Foley  catheter.  Objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. To assure continued compliance the following plan has been implemented: Regarding cited residents:  With respect to resident R199, the resident has discharged and experienced no complications related to the presence	F 656	plan, as appropriate requirements set for section. §483.21(b)(3) The by the facility, as or care plan, must- (iii) Be culturally-conthis REQUIREMENT by: Based on docume facility failed to deverson-centered care for an indwelling Form andicated R199) reversident (R199) reversident (R199) reversident (R199) reversident (R199) reversident (R199) was diagnosis which indicated R199 was diagnosis which indicated R199 had related to urinary reversident (R199) reversident	e, in accordance with the orth in paragraph (c) of this services provided or arranged utlined by the comprehensive impetent and trauma-informed. NT is not met as evidenced intreview and interview, the elop a comprehensive are plan which included care oley catheter for 1 of 2 viewed for catheter care.  ission record dated 12/26/23, with cluded sepsis (a serious from the presence of harmful the blood), and bacteremia od). Admission record further an indwelling Foley catheter etention.  Winimum Data Set (MDS) 1/10/23, indicated R199 was and had an indwelling Foley catheter etention.  In the comprehensive are plant with the blood of the catheter and lacked mention of a catheter and lacked	F 6	The preparation of the follow correction for this deficiency constitute and should not be as an admission nor an agrefacility of the truth of the fact conclusions set forth in the state deficiency. The plan of corresprepared for this deficiency solely because it is required of State and Federal law. When the foregoing statement, the that:  F656  It is the policy of Lyngbloms facility develop and implement comprehensive person-cent for each resident, consistent resident rights and includes objectives and timeframes to resident's medical, nursing, and psychosocial needs that in the comprehensive assess assure continued compliance following plan has been importally resident R15 resident has discharged and	does not e interpreted eement by the ement by the estatement of ection was executed by provisions without waiving a facility states tend care plant with the measurable to meet a and mental et are identified esment. To be the elemented:	

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		245347	B. WING		02/	16/2023	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
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LINGBL	OWSTEN CARE CEN	ILK		SAINT PAUL, MN 55108			
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F 656	Continued From pa	ge 22	F 6	356			
F 656	When interviewed of stated he has had a was admitted to the During an interview nursing assistant (Nothe care plan to care catheter. NA-B consinterventions to care catheter.  During an interview registered nurse (Rindwelling Foley care plan and state indwelling Foley care care plan and state indwelling Foley care care that R199 has know how to care for catheter. RN-D state have been that R19 would have been in plan.  During an interview	on 2/14/23, at 7:45 a.m. R199 a Foley catheter in since he facility on 12/26/22.  on 2/15/23, at 8:41 a.m. NA)-B stated that he follows for R199's indwelling Foley firmed the care plan lacked e for R199's indwelling Foley  on 2/15/23, at 8:45 a.m. N)-D confirmed R199's theter is not listed in R199's d that it was important that an theter be listed in the e plan so that all staff are as an indwelling catheter and for the indwelling Foley sed her expectation would sed her expectation would sed in R199's comprehensive care	F 6	prior to discharge. Actions taken to identify other poresidents having similar occurred. All other residents with catheters reviewed for proper care plan programmed and interventions related to indwelling catheters, all were appeared planned, no additions or reviewer needed.  Measures put in place to ensure practice does not occur: The nurse responsible to appropractice does not occur: The nurse responsible to appropractice does not needed and the care plan requirements for a resident with catheter. All other nurses that does not needed and review, or revise care plans have educated on the expectations are requirements for catheter care plan appropriately in place.  Effective implementation of action monitored by: Nursing administration will routing identify and review all residents and audit record for all interviews and audit record for all int	nces: were oblems, otheir oropriately visions  deficient riately vas a evelop, e been d ans and is not ns will be ely vith		
	indwelling Foley cat	(DON) confirmed R199's theter was not in R199's		regulatory and facility required e for the effective care and manage			
	•	e plan. DON stated his nave been that R199 's		an indwelling urinary catheter. Those responsible to maintain c	mnliance		
		heter would have been		will be:			
		comprehensive care plan.		The Director of Nursing and/or d	•		
	Facility policy titled	Comprehensive Care Plans,		four weeks for the required elem	•		
	dated 5/22, identifie	ed each resident would have a		including care plan problem, goa			
	_ •	mprehensive care plan		interventions. Then audit month	ly for 3		
		lemented to meet their		months to assure ongoing comp			
	· ·	als, and address their nental and psychosocial		The data collected will be present discussed monthly at the Quality			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING		· /	E SURVEY PLETED
		245347	B. WING			02/2	C 1 <b>6/2023</b>
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE	, ZIP CODE		10/2020
LYNGBL	OMSTEN CARE CENT	ΓER		1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD  THE APPROPE	BE	(X5) COMPLETION DATE
F 656	determine of the calinterventions and calinterther identified the would have been continued.	ge 23 dentified a CAA is used to re area triggers require are planning. The policy comprehensive care plan ompleted within 7 days of the omprehensive assessment.	F6	Assurance Committee Director of Nursing. At Quality Assurance com the decision/recommer any necessary follow-u actions. Completion date for ce only is 3-24-23.	that time the mittee will mandation regar p studies or	e nake rding	
	Bowel/Bladder Inco CFR(s): 483.25(e)(	ntinence, Catheter, UTI 1)-(3)	F 6	90 Silly 18 8 2 1 281			3/24/23
	resident who is con admission receives maintain continence	facility must ensure that tinent of bladder and bowel on services and assistance to unless his or her clinical mes such that continence is					
	incontinence, based comprehensive assence that— (i) A resident who exident's clinical continuous catheterization was (ii) A resident who exident who e	nters the facility without an is not catheterized unless the ondition demonstrates that necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder e treatment and services to it infections and to restore					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '			3) DATE SURVEY COMPLETED	
		245347	B. WING _			C 16/2023
	NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 690	incontinence, base comprehensive assensure that a reside receives appropriate restore as much no possible.  This REQUIREMENT by:  Based on observative review, the facility of catheter hygiene careviewed for cathete catheter, was at rischistory of urinary transitions include:  R138's face sheet, R138 was admitted to indwelling uninfection, mild cognized prostatic hyperplase enlargement), retended to indwelling uninfection, mild cognized prostatic hyperplase enlargement), retended to indwelling uninfection, mild cognized to indwelling uninfection.  R138's significant of the control of the complex of the comple	a resident with fecal d on the resident's sessment, the facility must ent who is incontinent of bowel te treatment and services to ormal bowel function as evidenced to provide routine are for 1 of 2 residents (R138), the orea of the faction, and an indwelling and the factions (UTIs).  The printed on 2/16/23, indicated to facility on 10/31/22.  The port, printed on 2/16/23, on and inflammatory reaction rethral catheter, urinary traction and inflammatory reaction are thral catheter, urinary traction of urine, and chronic (BPH)-prostate to ordinary to ordinary to ordinary to ordinary to ordinary ordinary report, printed assist of 1 dipersonal hygiene, had an and a diagnosis of urinary order summary report, printed	F 69	The preparation of the following p correction for this deficiency does constitute and should not be interpas an admission nor an agreemen facility of the truth of the facts alleg conclusions set forth in the statem deficiency. The plan of correction prepared for this deficiency was exsolely because it is required by proof State and Federal law. Without the foregoing statement, the facility that:  F690  It is the policy of Lyngblomsten that facility ensure that a resident who continent of bladder and bowel on admission receives services and assistance to maintain continence his or her clinical condition is or be such that continence is not possible maintain. A resident who enters the facility with an indwelling catheter of subsequently receives one is asset for removal of the catheter as soon possible unless the resident's clinic condition demonstrates that catheterizations is necessary. A resident was a constructed to the catheter as soon possible unless the resident's clinic condition demonstrates that	not reted t by the ged on ent of ecuted visions waiving y states the is unless ecomes le to ne or essed n as cal	
	on 2/16/23, indicate	ed foley catheter change every na shift starting on the 3rd and		who is incontinent of bladder receivages	ves	

F 690 Continued From page 25 ending on the 3rd every month, for protocol nurse to change catheter every month and as needed if plugged or bypassing, record number of cc's inserted in balloon, record size of french catheter inserted; foley catheter bag changes in the morning every Monday for protocol, staff changes leg and bed bags every week on bath day and as needed when leaking;  Doxazosin Mesylate (used to treat high blood pressure and urinary problems caused by an enlarge prostate tablet), Give 2 mg by mouth at bedtime for BPH related to benign prostatic hyperplasia with lower urinary tract symptoms.  R138's care plan, printed on 2/16/23, indicated R138 had self-care deficit related to recent decline in loss of function and required 1 staff to assist with dressing, grooming, bathing; had urinary retention due to BPH with lower urinary tract symptoms and chronic foley catheter use, required staff to change catheter bag weekly, empty urinary drainage bag at least every shift, more often if needed to keep the bag from becoming full, ensuring no kinks and urine is draining freely, to rinse out catheter bags with vinegar per protocol; maintain foley catheter per protocol; staff to observe/report changes in character of the urine such as color, clarify and	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE   1415 ALMOND AVENUE   SAINT PAUL, MN 55108			245347	B. WING			
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 690  Continued From page 25 ending on the 3rd every month, for protocol nurse to change catheter every month and as needed if plugged or bypassing, record number of cc's inserted in balloon, record size of french catheter inserted; foley catheter bag changes in the morning every Monday for protocol, staff changes leg and bed bags every week on bath day and as needed when leaking; Doxazosin Mesylate (used to treat high blood pressure and urinary problems caused by an enlarge prostate tablet), Give 2 mg by mouth at bedtime for BPH related to benign prostatic hyperplasia with lower urinary tract symptoms.  R138's care plan, printed on 2/16/23, indicated R138 had self-care deficit related to recent decline in loss of function and required 1 staff to assist with dressing, grooming, bathing; had urinary retention due to BPH with lower urinary tract symptoms and chronic foley catheter use, required staff to change catheter bag weekly, empty urinary drainage bag at least every shift, more often if needed to keep the bag from becoming full, ensuring no kinks and urine is draining freely, to rinse out catheter bags with vinegar per protocol; maintain foley catheter per protocol; staff to observe/report changes in character of the urine such as color, clarify and					1415 ALMOND AVENUE	<u>-</u>	
ending on the 3rd every month, for protocol nurse to change catheter every month and as needed if plugged or bypassing, record number of cc's inserted in balloon, record size of french catheter inserted; foley catheter bag changes in the morning every Monday for protocol, staff changes leg and bed bags every week on bath day and as needed when leaking; Doxazosin Mesylate (used to treat high blood pressure and urinary problems caused by an enlarge prostate tablet), Give 2 mg by mouth at bedtime for BPH related to benign prostatic hyperplasia with lower urinary tract symptoms.  R138's care plan, printed on 2/16/23, indicated R138 had self-care deficit related to recent decline in loss of function and required 1 staff to assist with dressing, grooming, bathing; had urinary retention due to BPH with lower urinary tract symptoms and chronic foley catheter use, required staff to change catheter bag weekly, empty urinary drainage bag at least every shift, more often if needed to keep the bag from becoming full, ensuring no kinks and urine is draining freely, to rinse out catheter bags with vinegar per protocol; maintain foley catheter per protocol; staff to observe/report changes in character of the urine such as color, clarity and	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	I SHOULD BE	COMPLETION
odor; assist with toileting cares and monitoring skin condition.  Review of record indicated R138 had foley catheter in place prior to facility admission, diagnosed with UTI while admitted to facility and completed antibiotic therapy on 11/1/22, had monthly foley catheter changes per staff on 11/9/22, 12/3/22, 1/14/23, and 2/5/23. A urine culture was obtained on 2/5/23 due to bladder symptoms of burning with urination reported per	F 690	ending on the 3rd eto change catheter plugged or bypassi inserted in balloon, inserted; foley cath morning every Monleg and bed bags eneeded when leaking Doxazosin Mesylate pressure and urinate enlarge prostate talbedtime for BPH rehyperplasia with low R138's care plan, pressure and urinate enlarge prostate talbedtime for BPH rehyperplasia with low R138's care plan, pressist with dressing urinary retention dutract symptoms and required staff to character symptoms and required staff to character of the urinary draining freely, to rivinegar per protocol; staff to obcharacter of the urinodor; assist with tois skin condition.  Review of record in catheter in place prediagnosed with UTI completed antibiotic monthly foley cathetall/9/22, 12/3/22, 1/2/3	every month, for protocol nurse every month and as needed if ng, record number of cc's record size of french catheter eter bag changes in the day for protocol, staff changes very week on bath day and as ng; e (used to treat high blood ry problems caused by an blet), Give 2 mg by mouth at lated to benign prostatic ver urinary tract symptoms.  For inted on 2/16/23, indicated deficit related to recent anction and required 1 staff to g, grooming, bathing; had be to BPH with lower urinary dichronic foley catheter use, ange catheter bag weekly, age bag at least every shift, and to keep the bag from uring no kinks and urine is nse out catheter bags with bl; maintain foley catheter per serve/report changes in the such as color, clarity and leting cares and monitoring dicated R138 had foley for to facility admission, while admitted to facility and content of the per staff on 11/1/22, had the rehanges per staff on 11/1/23, and 2/5/23. A urine	F 6	prevent urinary tract infection restore continence to the ext. To assure continued complifollowing plan has been imple Regarding cited residents: With respect to resident R11 plan, including care sheets, reviewed and updates made frequency of peri-care. Receshows the resident has not any complications from the peri-care noted on 2-16-23. Actions taken to identify oth residents having similar occur. All other residents. Measures put in place to empractice does not occur: All other residents with cath reviewed for proper care plareview of care sheets and frequency of care including the expension of monitored by:  All nursing staff that provide residents who have indwellicatheters have been re-edu proper peri-care for resident catheters, including the expension of the expectations and requency of the expectations and requency of the expectations and requency of the expectations and the peri-care. Policy for perines developed and implemented	itent possible. iance the blemented:  38, his care were e to indicate cord review experienced lack of her potential currences: hsure deficient heters were ans, including requency of ately care visions were  actions will be e care for ing urinary heat on hts with hectation that hely when s otherwise evelop, review, een educated quirements for completion of al care was d.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING _			C 16/2023
	NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 690	Review of nursing a printed on 2/16/23, R138's toileting car foley catheter cares R138's catheter bad document/update in remember to rinse vinegar per protocolocolocolocolocolocolocolocolocoloc	was negative at time.  assistant (NA) care sheet, indicated staff assist of 1-2 for es, staff to provide R138 with severy shift, staff to empty gs every shift-nurse with outputs, staff to R138's catheter bags with ol.  NA clinical skill I performance review, dated NA-E met competency to y so resident is clean and odor peri-care provided correctly trol technique, demonstrated		will be: The Director of Nursing and/or de will audit catheter listing report we four weeks for the required elemincluding care plan interventions, specifically peri-care frequency. audit monthly for 3 months to assongoing compliance. The data c will be presented and discussed at the Quality Assurance Commit meetings by the Director of Nursi that time the Quality Assurance owill make the decision/recommer regarding any necessary follow-uor actions.  Completion date for certification ponly is 3-24-23.	eekly for ents, Then sure ollected monthly tee ng. At committee ndation p studies	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING	}	02/	C / <b>16/2023</b>
NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	•	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 690	can, washed hands sink, grabbed pape threw paper towel in asked if she had concatheter earlier that catheter care not concatheter care not concatheter care had not routine morning care peri-care/foley catheter care had not provided, NA-E resprovided for R138 amovement (BM) earectal area only. Not care/foley catheter R138's shower days NA-E indicated routing care was not complisted when determined the days are reviewed to the facility, denied the days are reviewed, dindicated awareness are time when asked while interviewed, dindicated awareness needs, had not prove catheter care in passing the facility of the fa	res and placed into garbage with soap/water at bathroom retowels to dry hands and into garbage can. NA-E was impleted peri-care/foley morning, as peri-care/foley impleted at time of responded peri-care/foley of been completed during res. NA-E was asked when eter care was typically ponded peri-care was after R138 had a bowel rilier that morning, cleansing A-E stated routine peri care was completed on a and per R138's request, sine peri care/foley catheter eted on a daily basis. NA-E nining residents' care needs, aily NA care sheet, and are sheet did not list for eter care to be provided, only urinary bags, cleansing used egar solution, emptying shift as needed and recording ing conversation with NA-E, do not routinely provide peri stated he had a UTI while in naving any urinary symptoms.  On 2/16/23 at 8:58 a.m., NA-F s of R138's catheter care vided routine peri care/foley at for R138, stated licensed due to risk for infections with		690		

· , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING _			C 1 <b>6/2023</b>	
NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 690	licensed practical not NA's were trained to including cares for it stated NA's are explicated to care/catheter cares night for all resident with NA's towards expended. LPN-C care/catheter cares no special circumst to complete per LPI.  While interviewed, or director of nursing (receive training to procare/catheter care in needed (PRN), NA's off by licensed nurs were able and expended. The DON not need to indicate peri care/catheter care from the periodical periodical standard of staff.	non 2/16/23 at 9:02 a.m., urse (LPN)-C indicated all complete routine peri-cares, indwelling catheters. LPN-C pected to complete routine peri twice daily, in morning and at its, licensed nursing follows upend of shift to ensure task indicated R138's peri should be completed by NAs, ances for only licensed nurse N-C knowledge.  2/16/23 at 10:52 a.m., the DON) indicated all NA's provide routine peri upon hire, yearly, and as secomplete a checklist signed ing. The DON stated all NA's ected to provide routine peri for all residents during the cares, as well as whenever indicated NA care sheets did a NA's are to complete routine are for each resident, as eri care/catheter care was a care known to all nursing	F 69				
	Drainage and Leg Ereceived, did not income with indwelling cath Food Procurement, CFR(s): 483.60(i)(1		F 81	2		3/24/23	
	§483.60(i) Food saf The facility must -	ety requirements.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` '			TE SURVEY MPLETED	
		245347	B. WING			C 16/2023	
NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	<u>  UZI</u>	10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 812	Continued From pa	ige 29	F 8	12			
	approved or considentate or local author (i) This may include from local producer and local laws or received in accordance of the facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for serve food in accordance for food This REQUIREMED by:  Based on observative review, the facility food and produce refrigerator for food were identified and produce refrigerator furthermore, the facility for an accordance of the facility food and produce refrigerator for the facility for an accordance of the facility food and beautified to ensure equipment were apthe potential to affect the p	e food items obtained directly rs, subject to applicable State egulations. Toes not prohibit or prevent produce grown in facility compliance with applicable cod-handling practices. Toes not preclude residents ods not procured by the facility. Te, prepare, distribute and chance with professional		The preparation of the following placorrection for this deficiency does reconstitute and should not be interpolated as an admission nor an agreement facility of the truth of the facts alleg conclusions set forth in the statemed eficiency. The plan of correction prepared for this deficiency was exsolely because it is required by proof State and Federal law. Without with the foregoing statement, the facility that:  F812 It is the policy of Lyngblomsten that facility store, prepare, distribute, and serve food in accordance with professional standards for food ser safety. To assure continued complete following plan has been implement.	not reted by the ed on ent of ecuted visions vaiving states the d		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING _		02/	16/2023
NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 812	Continued From pa		F 8			
	that were not dated expired. CDM-A in manager (FPM)-B to inventory twice were dates and expiration expired. CDM-A statchecking food for odates, removing who indicated all left-over beverages when make from date opened, oper facility policy.  The following items:  Walk-in produce real. Small cubed pines approximately 3/4 furexpiration date; dried expiration date; dried approximately 3/4 furexpiration date; lettuce wet wire discoloration.  Cut up celery stick bag; approximately stalk wet with brown 4. Carrot sticks sea approximately 1/2 furexpiration date; dried buring an observate.  During an observate 2:48 p.m., noted died trays from dishwash tier of stand-up drying dripped downwards clean/air dried plast 3 plastic food storage.	or marked and/or were dicated food production ypically went through all food akly, checking food for opened in dates, removing food when ated all kitchen staff should be pened dates and expiration are expired as well. CDM-A er prepared food and arked were good for 3-7 days depending upon product and were observed during tour:  frigerator: apple fruit in facility container; all, opened date 2/7/23; no ed out, foul odor in original package; ad/undated; no expiration th occasional brown  acks sealed in zip-lock facility 1/2 full, dated 2/11/23; celery in discoloration at ends led in zip-lock facility bag; all; unmarked/undated; no ed out/shriveling  fon with CDM-A, on 2/13/23 at early aide (DA)-Z remove wet her, wet trays placed into top ing rack, water from wet trays onto open rack containing aic food storage container lids. ge container lids were		Regarding cited residents: Food items noted during survey to spoiled were discarded. All food areas have been inspected and a outdated or spoiled food items we discarded. Actions taken to identify other pot residents having similar occurrent All residents can potentially be aff deficient practice related to food a Measures put in place to ensure of practice does not occur: All food will be dated at the time of delivery, by facility staff or by veno Dates will be placed on the bulk packaging e.g. cases, flats, etc. I will use "best by" dates as a rough not expiration dates per industry standards, allowing for additional food items appear fresh and palar Produce is often not labeled with or "best by" dates so staff will evaluate each item for signs of rot or deter at time of use and discard if appears spoiled. Kitchen staff were re-edu on the signs of rot and deterioration. "Date opened" stickers will be filled and placed on opened items prior storage. Open produce will be disafter 7 days regardless of odor/appearance; however, it may discarded prior to 7 days if signs of deterioration are noted. Monitoring done will be done by the Food Promanager when orders are being pat least twice weekly. Staff will be re-educated as necessary when	ential ces: ected by ervice. deficient fable. days if able. duste for attention ars to be acated on. dout to scarded of rot or ag will be oduction or epared, experienced, exp	
	-	of the other, top plastic food d had several white, dried		knowledge deficits are identified.  have been reviewed and revised to		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		<b>'</b> '	(X3) DATE SURVEY COMPLETED	
		245347	B. WING			C 16/2023
NAME OF F	PROVIDER OR SUPPLIER	•	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CO	DDE .	
LVNCDL		TED		1415 ALMOND AVENUE		
LYNGBL	OMSTEN CARE CEN	IEK		SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 812	Continued From pa	ngo 31		212		
1 012	•		ГС	312		
	areas, which resem	nbled water spots.		how items will be labeled and	•	
	During an observat	ion with CDM-A, on 2/15/23 at		they may be kept. Leftover/ will be used or discarded wit	• •	
	•	emoved pan of skewered		(this does not apply to unope	•	
	ŕ	set pan on food prep table,		produce). Staff were re-edu		
	•	ter from kitchen drawer,		proper handling/stacking of i		
		p from tip of thermometer,		drying rack, items will be ren		
	inserted tip of thern	nometer into skewered shrimp		stored in the appropriate sto	rage areas	
	to temp shrimp, rer	noved thermometer from		only when completely dry. C	care will be	
	• •	ed tip of thermometer, set		taken to not place wet items	•	
	thermometer down	on food prep table.		items as able, if a wet item of	•	
	\	0/40/00 -+ 0·40		dry item both items will rema		
	-	on 2/13/23 at 2:10 p.m.,		drying rack until dry. Staff re	•	
		hen food and beverage items acility, staff would rotate food		taking food temperatures we issued their own thermometer		
		food items towards the front,		re-educated regarding how t		
	′ <b>I</b>	owards the back, older food		take a temperature and whe		
		o first. CDM-A stated when		sanitize the thermometer.		
	•	ened, staff were to mark date		Effective implementation of	actions will be	
	when opened so st	aff would be aware of when to		monitored by:		
	discard items if bey	ond facility policy expiration		The Director of Culinary and	Nutritional	
		ated staff should be checking		Services and/or designee wi		
		, if food appeared dry,		storage areas for proper lab	<b>O</b> ,	
	•	reased moisture, or was foul		and odor/appearance weekly	•	
	smelling, tood shot	ıld be discarded immediately.		month, then biweekly for two		
	During an interview	, on 2/15/23 at 10:41 a.m.,		Those responsible to mainta will be:	iii compliance	
	•	uld typically cleanse tip of		Director of Culinary and Nuti	ritional	
		alcohol wipe prior to and after		Services will review their res		
	insertion of food wh	• •		information, concerns noted	•	
		. •		corrective actions taken, cor		
	•	on 2/15/23 at 10:47 a.m.,		information before presentin	g to the	
		Il staff temping food should be		monthly Quality Assurance C		
	<b>O</b> .	rmometer with alcohol wipe		meetings for discussion. At		
	prior to and after in	sertion into food.		Quality Assurance committe		
				the decision/recommendation	•	
		Food Storage, reviewed date		any necessary follow-up stud	ales or	
	•	; leftover food will be stored in or wrapped carefully and		actions.  Completion date for certifica	tion nurnoses	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING		02/16/2023	
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CO  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 812	Continued From pa	ige 32	F {	312		
	dated before being used within 7 days Federal Food Code assure that foods (it consumed by their discarded.  Facility policy titled Dating of Food, revorting of Food, revorting and freezer will be the cooks and dietary roper rotation, all within 48-72 hours Production Manage freezer for uncover due when major or and dietary aides a	refrigerated, leftover food is or discarded per the 2017 e; all foods will be checked to including leftovers) will be safe use dates, or frozen, or  Covering, Labeling, and riewed date 11/22, consisted ed in the walk-in refrigerator covered, labeled, and dated by ary aides to ensure safety and food items shall be discarded of labeled date, the Food er will inspect the walk-ins and ed, unlabeled or dates past dering is done 2x/week, cooks re also responsible to discard hem or bring it to attention of		only is 3-24-23.		
	UTENSILS, and LII SINGLE-SERVICE 4-901.11 Equipment Required. Items must be allow before being stacked items such as panel and may allow an emicroorganisms can Equipment Food-C Equipment food-conshall be cleaned: be type of raw animal lamb, pork, or POU change from working	D22, clean EQUIPMENT, NENS; and unwrapped and SINGLE-USE ARTICLES. Int and Utensils, Air-Drying wed to drain and to air-dry ed or stored. Stacking wet a prevents them from drying environment where in begin to grow. 4-602.11 ontact Surfaces and Utensils. Intact surfaces and utensils efore each use with a different FOOD such as beef, FISH, ULTRY; Each time there is a fing with raw FOODS to working AT FOODS; Between uses				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. B		IPLE CONSTRUCTION  NG	' '	(X3) DATE SURVEY COMPLETED	
245347	B. WING _			C <b>02/16/2023</b>	
NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
with raw fruits and vegetables and with TIME/TEMPERATURE CONTROL FOR SAFE FOOD; Before using or storing a FOOD TEMPERATURE MEASURING DEVICE; At an time during the operation when contamination may have occurred.  F 880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)  §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicab diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection preventing and control program (IPCP) that must include, a minimum, the following elements:  §483.80(a)(1) A system for preventing, identifying reporting, investigating, and controlling infection and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessme conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2) Written standards, policies, and procedures for the program, which must include but are not limited to:  (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	re le on at on at on at on at one on at one on at one			3/24/23	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION  G	COMPLETED	
		245347	B. WING		C 02/16/2023
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 880	communicable disereported; (iii) Standard and transport linens so infection.  Sassed on observare and update the This REQUIREMED and transport linens so insection.	ity; nom possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism  that the isolation should be the esible for the resident under the ces under which the facility eyees with a communicable skin lesions from direct ints or their food, if direct the disease; and he procedures to be followed direct resident contact.  Stem for recording incidents of facility's IPCP and the aken by the facility.  Indle, store, process, and as to prevent the spread of  review. Cuct an annual review of its heir program, as necessary.  No interview, and document  tion, interview, and document		The preparation of the following pl	
	_	ailed to follow Centers for caid Services (CMS) and		correction for this deficiency does constitute and should not be interp	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		l \ /	(X3) DATE SURVEY COMPLETED	
		245347	B. WING			C <b>16/2023</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	10/2023
LYNGBLOMSTEN CARE CENTER			1415 ALMOND AVENUE SAINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From pa		F 8			
	prevent the spread Covid-19 outbreak transmission, resid observed not weari protective equipme This had the potent who resided in the	e Control (CDC) guidelines to of Covid-19, when during a and high Covid-19 community ents, visitors and staff were ng appropriate personal nt (PPE), specifically masks. tial to affect all 211 residents facility.		as an admission nor an agree facility of the truth of the facts conclusions set forth in the state deficiency. The plan of corresponded for this deficiency was solely because it is required of State and Federal law. With the foregoing statement, the that:	s alleged or tatement of ction was executed by provisions thout waiving	
	who was admitted of Covid-19 on 2/7/23 based precautions.	outbreak status when R307, on 2/3/23, tested positive for , and was in transmission In addition, the county ssion level for Covid-19 was		F880 It is the policy of Lyngblomster Center that the facility establishmaintain an infection control designed to provide a safe, so comfortable environment and prevent the development and transmission of communicable	ish and program anitary and d to help	
	observed two signs facility regarding visions were on the door as facility. Both signs were denza inside the the receptionists destop and look for the them. The two sign ATTENTION VISIT to the Care Center complete a Covid-1 temperature check However, we ask the you are experiencing the following: tested 10 days, have Covid-10 days, have Covid-10 days. Colose contact with a the last 10 days. Colose the contact with a the last 10 days. Colose contact with a the last 10 days.	ion on 2/13/23, at 3:30 p.m., at the main entrance of the sitor masking. Neither signs individuals entered the were laying flat, one on a main entrance and one on esk. A visitor would need to e signs in order to see/read atted 11/29/22, read: ORS AND GUESTS: Visitors are no longer required to 9 entrance questionnaire or when entering the building at you refrain from visiting if ag or have experienced any of dipositive for Covid in the last d-like symptoms, have had a Covid-positive individual in arrently visitors are asked to sor masks when visiting		and infections. To assure co- compliance the following plan- implemented. Regarding cited residents: With respect to residents refe- the summary statement: R13 R163, R255, R101, R85, R12 R49, R131, R26, R129, R119 R97, R53 have all been indiv- informed of the current requi- mask when outside their room eating. Signage informing in- the current masking requirent the building have been relocated and perspectives that afford a visibility and readability. Sign been revised to indicate the community transmission level outbreak status and the appr masking requirement.	ntinued n has been erenced in 80, R148, 26, R65, R32, didually rement to ms and not dividuals of nents within ated to areas greater hage has current el, building	
	wear face covering	-		• •	•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245347	B. WING			C <b>16/2023</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	10/2020	
				1415 ALMOND AVENUE			
LYNGBL	OMSTEN CARE CEN	TER		SAINT PAUL, MN 55108			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG			COMPLÉTION DATE	
F 880	Continued From pa	ige 36	F 8	880			
	in the surrounding	community.		residents having similar occ	urrences:		
				All residents have an increas	sed risk of		
	_	ion on 2/13/23, at 3:45 p.m., a		infection when recommende	ed masking		
	•	n a wall entering the TCU		requirements are not followed			
		nit) on first floor. The sign		Measures put in place to en	sure deficient		
		d a large red stop sign followed		practice does not occur:	- 4l - <b>6</b> 4		
		lunteers MUST wear a face		Root Cause Analysis complete			
		sident care area. Visitors are ed to wear face masks as well.		facilities failure to properly for source control masking requ			
	Subligly elicoulage	d to wear face masks as well.		Causal factors revealed info			
	During an interview	on 2/14/23, at 2:40 p.m., the		deficits among residents and			
	_	f nursing (ADON)-E was		visitors related to a failure to			
		ations of visitors entering the		communicate masking requi	•		
	facility, walking pas	t the reception desk and		to correct identified ongoing	deficits. Also		
		tor without masking.		identified were conflicting m	0 0		
		tion of the signs, (laying flat on		masking requirements by th	•		
	, ,	ent of the signs not being		poor visibility of that messag	, ,		
	, , ,	y people as they entered the		implemented to re-educate			
	,	E stated she was aware of the		visitors using effective mess	0 0		
	interpreted it as bei	dance for visitor masking, but		a variety of methods, includi limited to: individual commu	•		
	interpreted it as bei	ing optional.		enhanced signage, written	mcauons,		
	During an interview	and observation on 2/15/23,		communications, and verbal	l reminders		
		ADON-E was asked to observe		Key personnel at entrance lo			
		eplace/elevators sitting in a		been instructed to monitor for			
		None had masks on. While		compliance among visitors a	and others and		
	these individuals w	ere not in a resident care area		how to effectively inform the	individuals of		
	,	ad walked a distance into the		the current masking require			
	_	ning masks. The ADON-E		dispensing stations have be	•		
		ors choice not to wear a mask.		key entrances- visitor and e	•		
		owledged the Covid-19		along with signage to remind			
		ssion rate was high and the		the masking requirements a	•		
	Tacility was in Covid	d-19 outbreak status.		easily accessible masks. Administration mask dispensers have been	• •		
	Observations and i	nterviews of RESIDENT		and will be placed in key loc	•		
	masking:			throughout the building for e			
		0:30 a.m., 14 unmasked		to staff, residents and visitor			
		148, R163, R255, R101, R85,		routinely provide masks for			
	,	49 R131 R26 R129 R119)		Three new policies have been			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING _			C <b>16/2023</b>	
	PROVIDER OR SUPPLIER	ΓΕR		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	ge 37	F 88	30			
	on third floor. The atto 11:20 a.m.  On 2/15/23, at 11 (TC)-A stated resid recommended for a	nding live music by a singer activity lasted from 10:30 a.m.  :29 a.m., therapy coordinator ent masking had not been awhile, adding she did not as to wear a mask as she had		address, masking, gown wearing PPE use during conventional, contingency, and crisis capaciti Masking as Source Control, Go Transmission Based Precaution Optimizing PPE. Facility Infection policy was reviewed and remain consistent with current requirer	es: wn Use for ns, and on Control ns		
	_	was required for residentsit		recommendations, no changes made. Facility COVID-19 Infection Control policy was reviewed du	were tion		
	masking was a choose than mandatory and resident, as some of was needed. TC-B residents if they was consistently. TC-B facility was in Covidents.	:47 (TC)-B stated she thought ice for the residents rather of that it depended on the did not understand why a mask stated she sometimes asked inted a mask, but did not do it stated she had not heard the l-19 outbreak status.		survey and revised at that time have been re-educated on the and requirements of source commasking. All Nursing staff have re-educated on the proper use including the donning and doffin Staff will be required to demons competency in the proper use Residents and their representations.	All staff ourpose itrol been of, ig, all PPE. strate of PPE. sives will be		
	a wheelchair, self pallway near the direct to wear a mass staff encouraged he outside of her room tell us to unless we According to quarte	ropelling in her third floor ning room stated, "We don't sk anymore." When asked if er to wear a mask when n, R101 replied, no, "They don't re going to the doctor." erly Minimum Data Set (MDS) 11/9/22, R101 was cognitively		educated on the purpose of soumasking, it benefits, how mask requirements are determined a that information will be communithem.  Effective implementation of act monitored by:  The Infection Preventionist and designee will audit PPE- both the donning and doffing of PPE by the appropriate use of source of	ng nd how nicated to ons will be for ne proper staff and		
	her recliner watching knew if residents no out of their room and that, or had staff as outside of her room.	52 p.m., R56 was resting in g TV. R56 was asked if she eded to wear masks when d replied no one had told her ked her to wear a mask a. According to admission MDS 1/15/23, R56 was cognitively		masking for all staff, residents a visitors. Donning and doffing a occur weekly, as able, determing place transmission-based precadudits of source control masking completed for all shifts four time for one week and that twice we one week after 100% complian	and udits will ed by in autions. g will be e a week ekly for		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245347	B. WING _		02/	C <b>16/2023</b>
LYNGBL	PROVIDER OR SUPPLIER  OMSTEN CARE CENT	TEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108  PROVIDER'S PLAN OF CORRECT		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		JLD BE	(X5) COMPLETION DATE
F 880	a resident hallway of floor, on her way to didn't think she had "Staff haven't remin quarterly MDS asses was cognitively inta On 2/15/23, at 3:5 earlier on first floor mask on, and who haptop stated, "I we but not in the hallwat told I need to." Accassessment dated intact.  On 2/15/23, at 3:5 hallway on third floor side by side with R8 wheelchair. R53 was R87's mask was be don't think we have tell me to." According assessment dated intact.  On 2/16/23, at 8:5 (NA)-D on third floor required for resident room; masks were observations and in masking:  On 2/14/23, at 3:4 (FM)-F was on four way to the coffee she	40 p.m., R120 was walking in with her walker on second play cards. R120 stated she to wear a mask anymore and, ded me." According to essment dated 12/28/22, R120	F 88	Infection Preventionist will monitor infection trends and report any sto be linked to improper PPE use including source control masking. Those responsible to maintain cowill be:  The Root Cause Analysis was rewith the Quality Assurance Command the Governing Body Preside ongoing audit data collected will presented to the Quality Assurancemmittee by the Infection Prevented to the Quality Assurancemental will be reviewed/discussed at the month Assurance Meeting. At that time Quality Assurance committee will the decision/recommendation reany necessary follow-up studies. Completion date for certification only is: 3-24-23.	uspected  ; I. I. Impliance viewed nittee nt. Any be ce entionist  Ily Quality the I make garding	

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245347	B. WING		02	C 2/16/2023
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP COI 1415 ALMOND AVENUE SAINT PAUL, MN 55108	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AF  DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	On 2/15/23, at 2: unmasked was obselfloor on his way to never wore a mask needed to but was mask. FM-G visited On 2/16/23, at 8: unmasked, was in nurses station talki FM-H stated he has facility for quite awl him he should. FM-about 50% of the ti On 2/16/23, 9:03 receptionist (R)-I, win visitor masking, sto wear a mask if the visitor masking to be During an interview DON stated the AD visitor and resident they would do a little masks, adding they residents, but could they would do a little masks, adding they residents, but could they would do a little masks, adding they residents, but could they would do a little masks, adding they residents, but could they would do a little masks, adding they residents, but could they would do a little masks, adding they residents, but could they would do a little masks, adding they residents, but could they would do a little masks, adding they residents, but could they would do a little masks. During an interview of residents and residents.	s told me I need to." FM-F d wear a mask, she would.  40 p.m., (FM)-G who was served in the hallway on fourth see R52. FM-G stated he c; no one had told him he not opposed to wearing a d R52 daily.  52 a.m., (FM)-H who was the hallway on third floor at the ng to nursing assistant (NA)-D. d not worn a mask in the hileadding no one had told hallway on the hallway	F 8	880		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	DING	COMPLETED	
		245347	B. WING		02/	C 16/2023
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE	(X5) COMPLETION DATE
F 880	Covid-19 outbreak community transmist Covid-19 had been residents didn't war adding many stopp and they could see of it [Covid-19]. The re-educated resident didn't know if anyor admitted in her role to bring up re-educated visitors stopped we was last fall. Discussed using the residents who were wear a mask, as the staff to identify those who wanted to be reducation for residents and interview (ADON)-D who attempted to resident to resident. During an interview (ADON)-D who attempted to be reducation for resident. During an interview (ADON)-D who attempted to resident to resident. During an interview (ADON)-D who attempted to resident to resident to resident to resident. During an interview (ADON)-D who attempted to resident to resid	andatory, even during status and during high ssion. The ADON-E stated going on a long time and at to wear masks anymore, ed taking Covid-19 boosters residents were sick and tired a ADON-E stated she had not at son wearing masks and he else had. The ADON-E she would likely be the one ation to the leadership team. not recall when residents and aring masks, but thought it e care plan to identify a not able to or did not want to be residents from residents eminded to wear a mask.  If on 2/16/23, at 11:05 a.m., the facility did not have a policy masking.  If on 2/16/23, at 11:33 a.m., anded resident council by had not done any recent		880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245347	B. WING _				C <b>16/2023</b>	
	PROVIDER OR SUPPLIER	ΓΕΝ		STREET ADDRESS, CITY, STATE, ZIP ( 1415 ALMOND AVENUE SAINT PAUL, MN 55108	STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPR	BE	(X5) COMPLETION DATE	
F 880	DON indicated staff mask immediately of the prevention of Caminimize exposures. The Care Center work CDC and CMS web information and resignidance for visitati CMS Memorandum. The facility would uncovering or masking reduce the risk of C given source control to protect staff and transmission of potential path and transmission of potential path and transmission of potential path age. Staff could into access their mounts.	p.m. during an interview the fwere expected to wear a entering the building, p.m. during an interview for nursing (ADON)-E stated a mask prior to entering a and confirmed masks were at the back employee  Covid-19 Infection Control rised date of 2/13/2023, see was to provide guidance on ovid-19 and to prevent and as to respiratory pathogens. Ould regularly monitor the osite's for the most up to date ources, and would adhere to on detailed within revised a QSO 20-39 dated 9/23/22. Itilize core principles of face g when permitting visitation to covid-19 and visitors would be of facemasks. PPE was used residents from the entially dangerous and/or as. Face masks would be all times when in resident care nomentarily lower their mask at the anonly lower their mask when a	F 8	80				

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

F5347034

(X2) MULTIPLE CONSTRUCTION

PRINTED: 04/17/2023 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01		COMPLETED	
		245347	B. WING _		02/	14/2023
	PROVIDER OR SUPPLIER	ΓER		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	-S	K 0	00		
	FIRE SAFETY					
	conducted by the Menth Public Safety, State 02/14/2023. At the Lyngblomsten Care compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe edition of National F (NFPA) 101, Life Safe edition of National F (NFPA) 99, Health Carn NFPA 99,	Center was found not in requirements for participation id at 42 CFR, Subpart by from Fire, and the 2012 Fire Protection Association afety Code (LSC), Chapter 19 ie and the 2012 edition of are Facilities Code.  OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.  F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.  THE PLAN OF R THE FIRE SAFETY TAGS) TO:  IN THE E-POC PROCESS, A THE PLAN OF CORRECTION				
.ABORATOR\	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Flectron	ically Signed					03/16/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG 01 - MAIN BUILDING 01	· /	(X3) DATE SURVEY COMPLETED	
		245347	B. WING _		02	/14/2023
	PROVIDER OR SUPPLIER  OMSTEN CARE CEN			STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH APPENDED TO THE APPENDENCY)	ULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUSE FOLLOWING INFO.  1. A detailed described taken or planned to a sure the sustained to a sustained.  2. Address the magnitude performance sustained.  4. Identify who is actions and monito.  5. The actual or puther remedy.  Lyngblomsten Care with a full basemer constructed at two building was constructed at two building was constructed to be on 1976, an addition was constructed to be on 1976, an addition was constructed at two puts of the constructed to be on 1976, an addition was constructed at two puts of the constructed to be on 1976, an addition was constructed at two puts of the constructed at t	Expections Division Suite 145 1-5145, OR  S@state.mn.us  RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:  cription of the corrective action of correct the deficiency.  easures that will be put in e deficiency does not reoccur.  The facility plans to monitor e to ensure solutions are  responsible for the corrective oring of compliance.  Proposed date for completion of eaction of the corrective oring of compliance.  The building was different times. The original ructed in 1962 and was of Type II(222) construction. In ovas constructed to the	K 00			
	Southside that was II(222) construction and the one addition	determined to be of Type  n. Because the original building  n are of the same type of  acility was surveyed as one				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>`</b> ′	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	` '	(X3) DATE SURVEY COMPLETED	
		245347	B. WING _		02/	14/2023	
	PROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
K 000	system. The facility full corridor smoke the corridors that a department notification.  The facility has a calculated and the corridors.	ected by a full fire sprinkler has a fire alarm system with detection and spaces open to re monitored for automatic fire	K 00				
K 761 SS=F	Maintenance, Inspected Maintenance, Inspected Maintenance, Inspected for Fire Doors and Non-rated doors, in patient rooms and routinely inspected maintenance programination of the sting possess know that demonstrates Written records of in maintained and are 19.7.6, 8.3.3.1 (LSC 5.2, 5.2.3 (2010 NFT) This REQUIREMENT by:  Based on a review and staff interview, inspect Fire doors Life Safety Code, see the staff of the s	ection & Testing - Doors lies are inspected and tested ance with NFPA 80, Standard Other Opening Protectives. Including corridor doors to smoke barrier doors, are as part of the facility am. Ining the door inspections and owledge, training or experience ability. Inspection and testing are e available for review. C)	K 76	K761 To meet the requirements of maintenance, inspection and test doors, fire doors assemblies are inspected and tested annually in	•	4/3/23	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>,</b> ,	1 ` '			TE SURVEY MPLETED	
		245347	B. WING		02/	14/2023	
	PROVIDER OR SUPPLIER  OMSTEN CARE CEN	TER	14	TREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE AINT PAUL, MN 55108			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K 901	Findings include:  On 02/14/2023 at 0 observation or a redocumentation that annual fire door instantial annual fir	ent within tehfacility.  1920 AM, it was revealed by view of available the facility did not conduct pections.  1920 acility did not conduct pections.  1920 acility Director of Maintenance of finding at the time of the facility Director of Maintenance of the finding at the time of the finding at the time of the finding System Categories are designed to meet Category ments as detailed in NFPA 99.  1920 acronice to meet Category ments as detailed in NFPA 99.  1921 acronice to meet Category ments as detailed in NFPA 99.  1922 acronice to meet Category ments as detailed in NFPA 99.  1923 acronice to meet Category ments as detailed in NFPA 99.  1924 acronice to meet Category ments as detailed in NFPA 99.  1925 acronice to meet Category ments as detailed in NFPA 99.  1925 acronice to meet Category ments as detailed in NFPA 99.  1926 acronice to meet Category ments as detailed in NFPA 99.  1926 acronice to meet Category ments as detailed in NFPA 99.  1927 acronice to meet Category ments as detailed in NFPA 99.  1928 acronice to meet Category ments as detailed in NFPA 99.  1928 acronice to meet Category ments as detailed in NFPA 99.  1929 acronice to meet Category ments as detailed in NFPA 99.  1920 acronice to meet Category ments as detailed in NFPA 99.  1920 acronice to meet Category ments as detailed in NFPA 99.	K 761	Fire Doors and Other Opening Protectives. Physical Plant staff wil inspect fire doors and document sa Physical Plant Director will audit for compliance.  Date completed by 04-03-2023	ame.	4/3/23	
	by: Based on a review and staff interview, an all hazards risk a edition), Health Carthis deficient finding	of available documentation the facility failed to implement assesment per NFPA 99 (2012 re Facilities Code, Chapter 4. In g could have a widespread ents within the facility.		K901 To meet requirements of implement hazard risk assessment per NFPA (2012 edition), Health Care Facilities Code, Chapter 4, the facility safety committee implemented an all hazarisk assessment. Physical Plant Supervisor will assure review for compliance annually.	99 es		

	$\mathbf{I}$ '		` '	E SURVEY IPLETED		
		245347	B. WING		02/	14/2023
	PROVIDER OR SUPPLIER  OMSTEN CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP COD 1415 ALMOND AVENUE SAINT PAUL, MN 55108	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 901	review of available	0920 AM, it was revealed by a documentation that the facility ent copy of their Health risk	K 9	Date completed by 04-03-2023	3	
<b>K 914</b> SS=F	verified this deficie discovery Electrical Systems	ne Director of Maintenance Int finding at the time of  - Maintenance and Testing	K 9	14		4/17/23
	Hospital-grade recollocations and when anesthesia is administallation, replace testing is performed documented performed documented performed documented performed as hospital-graded at intervals isolation monitors (intervals of less that actuating the LIM to which activates both LIM circuits with aumanual test is perfered at the equal to 12 months 6.3.3.3.2 after any electric distribution maintained of require area tested, and refered area tested, and refered as the equal to 12 months for the equal to	- Maintenance and Testing eptacles at patient bed e deep sedation or general nistered, are tested after initial ement or servicing. Additional d at intervals defined by mance data. Receptacles not rade at these locations are not exceeding 12 months. Line (LIM), if installed, are tested at an or equal to 1 month by est switch per 6.3.2.6.3.6, th visual and audible alarm. For atomated self-testing, this formed at intervals less than or s. LIM circuits are tested per repair or renovation to the system. Records are ired tests and associated tions, containing date, room or sults.  NT is not met as evidenced of available documentation the facility failed to conduct - Maintenance and Testing per		K914 To meet requirements of all re electrical receptacles being tes		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	<b>  `</b>	LE CONSTRUCTION  01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245347	B. WING		02/14/2023	
	PROVIDER OR SUPPLIER	ΓER	1	STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
K 916	Code, section 6.3.4 have a widespread the facility.  Findings include:  On 02/14/2023 at 0 review of available has not did their an rooms.  An interview with Dethis deficient finding Electrical Systems CFR(s): NFPA 101  Electrical Systems Alarm Annunciator A remote annunciate powered is provided generating room in operating personner hard-wired to indicate emergency powers system (e.g., building to be substituted for 6.4.1.1.17, 6.4.1.1.1 This REQUIREMENT by:  Based on observating facility failed to main Alarm Annunciator Health Care Facilities This deficient finding	tion), Health Care Facilities This deficient finding could impact on the residents within  930 AM, it was revealed by a documentation that the Facility nual outlet testing for resident  irector of Maintenance verified at the time of discovery. Essential Electric Syste  tor that is storage battery to operate outside of the a location readily observed by a location readily observed by the alarm conditions of the source. A centralized computering information system) is not readily on the alarm annunciator.	K 914	annual basis per NFPA 99, section 6.3.3.2 through 6.3.3.2.4 and 6.3.4. Physical Plant staff will initiate and complete annual testing and documentation of all non-hospital gresident room electrical receptacle Physical Plant Supervisor will audit compliance on a periodic basis.  Date completed by 04-17-2023	1.3, grade s. for  4/3/23  hg a h) the top en and or will	
	J ====================================					

	TATEMENT OF DEFICIENCIES  ND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED			
		245347	B. WING			02/	14/2023
	PROVIDER OR SUPPLIER  OMSTEN CARE CENT	ΓER		14	TREET ADDRESS, CITY, STATE, ZIP CODE 415 ALMOND AVENUE 5AINT PAUL, MN 55108		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 916	observation the emgenerator was located the 1st floor nursing the	0:30 AM, it was revealed by ergency stop button for the ted behind a shelving unit on	K 9	16	periodic basis.  Date completed by 4-03-2023		



#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 8, 2023

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

Re: State Nursing Home Licensing Orders

Event ID: YR5J11

#### Dear Administrator:

The above facility was surveyed on February 13, 2023 through February 16, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order 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 <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04</a> 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Lyngblomsten Care Center March 8, 2023 Page 2

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		D WING		С	
	00501	B. WING		02/16/2023	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LYNGBLOMSTEN CARE CENT	ER	OND AVENU UL, MN 551			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
2 000 Initial Comments		2 000			
*****ATTE	NTION*****				
NH LICENSING	CORRECTION ORDER				
144A.10, this correct pursuant to a surve found that the defication herein are not corrected shall with a schedule of the Minnesota Department of which corrected requires of the number and MN Ru When a rule contain comply with any of the lack of compliance. re-inspection with a	nether a violation has been				
	ring the initial inspection was				
that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
complaint survey was surveyors from the Health (MDH). Your compliance with the following correction	S: , a licensing survey and as conducted at your facility by Minnesota Department of facility was NOT in MN State Licensure and the orders are issued. Please stronic plan of correction you				

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

(X6) DATE

**Electronically Signed** 

03/15/23

If continuation sheet 1 of 23

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S	
		/\. BOILDING.			
	00501	B. WING		02/1	, 6/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE	•	
NAME OF FROVIDER OR SOFFLIER		IOND AVENU			
LYNGBLOMSTEN CARE CENT	ER	UL, MN 551			
(Y4) ID SUMMARY STAT	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	COMPLETE DATE
2 000 Continued From page	ge 1	2 000			
have reviewed these when they will be co	e orders and identify the date mpleted.				
deficiency issued, H H53478214C(MN00 H53478209C(MN00 H53478207C(MN00 H53478206C(MN00 Minnesota Departmethe State Licensing Federal software. Ta assigned to Minneso Nursing Homes. The appears in the far le Tag." The state stat listed in the "Summa column and replaces the correction order the findings which a statute after the stat as evidence by." Fol findings are the Sug and Time Period for You have agreed to receipt of State licer the Minnesota Depa Informational Bulleti http://www.health.sta obul.htm. The State delineated on the at Department of Healt you electronically. A is necessary for Stat enter the word "COF available for text. Yo electronic State licer	1083852), 1085747), 1087959), and 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679). 1090679 109067				

Minnesota Department of Health

STATE FORM YR5J11 If continuation sheet 2 of 23

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00501	B. WING			C 1 <b>6/2023</b>
NAME OF E	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	<u>.                                      </u>	
		1415 ALM	IOND AVENU			
LYNGBL	OMSTEN CARE CENT	SAINT PA	UL, MN 551	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	is enrolled in ePOC not required at the k state form.	artment of Health. The facility and therefore a signature is ottom of the first page of RD THE HEADING OF THE				
		N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.				
2 565	MN Rule 4658.0405 Plan of Care; Use	Subp. 3 Comprehensive	2 565			3/24/23
	-	mprehensive plan of care personnel involved in the				
	by: Based on documen facility failed to developerson-centered cafor an indwelling Fo	ent is not met as evidenced t review and interview, the elop a comprehensive re plan which included care ley catheter for 1 of 2 iewed for catheter care.		Corrected		
	Findings include:					
	indicated R199 was diagnosis which inc condition resulting f microorganisms in t (bacteria in the block	ssion record dated 12/26/23, admitted on 12/26/23, with luded sepsis (a serious rom the presence of harmful the blood), and bacteremia d). Admission record further an indwelling Foley catheter tention.				

Minnesota Department of Health

STATE FORM YR5J11 If continuation sheet 3 of 23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00 50 4	B. WING		C	
		00501	B. WING		02/1	6/2023
NAME OF	PROVIDER OR SUPPLIER		, ,	TATE, ZIP CODE		
LYNGBL	OMSTEN CARE CENT	ΓER	IOND AVENU UL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	assessment dated	Ainimum Data Set (MDS)  1/10/23, indicated R199 was  Id had an indwelling Foley				
		nent (CAA) dated 1/12/23, an indwelling Foley catheter tention.				
	an indwelling Foley	ated 1/5/23, lacked mention of catheter and lacked e for an indwelling Foley				
	stated he has had a	on 2/14/23, at 7:45 a.m. R199 a Foley catheter in since he facility on 12/26/22.				
	nursing assistant (Note that care plan to care catheter. NA-B cont	on 2/15/23, at 8:41 a.m. NA)-B stated that he follows e for R199's indwelling Foley firmed the care plan lacked e for R199's indwelling Foley				
	registered nurse (Rindwelling Foley cate plan and state indwelling Foley cate comprehensive care aware that R199 had know how to care for catheter. RN-D state have been that R19 would have been in plan.	on 2/15/23, at 8:45 a.m. N)-D confirmed R199's theter is not listed in R199's d that it was important that an theter be listed in the e plan so that all staff are as an indwelling catheter and or the indwelling Foley ed her expectation would 99's indwelling Foley catheter R199's comprehensive care				
	During an interview	on 2/15/23, at 11:30 a.m.				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00501	B. WING			C 1 <b>6/2023</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
LYNGBL	OMSTEN CARE CENT	ΓER	OND AVENUUL, MN 551			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	 ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	indwelling Foley cate comprehensive care expectation would have been cate indwelling foley cate included in R199's of the facility policy titled dated 5/22, identified person-centered condeveloped and implementations and go medical, physical, in needs. The policy is determine of the calinterventions and catefurther identified the would have been categories.	cheter was not in R199's e plan. DON stated his nave been that R199 's neter would have been comprehensive care plan.  Comprehensive Care Plans, ed each resident would have a mprehensive care plan lemented to meet their nental and psychosocial dentified a CAA is used to re area triggers require are planning. The policy e comprehensive care plan ompleted within 7 days of the omprehensive assessment.				
	The director of nurse review and revise part to ensuring the care resident is followed designee could develop a monitare providing care a of care.	HOD OF CORRECTION: sing (DON) or designee could colicies and procedures related e plan for each individual . The director of nursing or elop a system to educate staff itoring system to ensure staff as directed by the written plan  R CORRECTION: Twenty-one				
2 835		Subp. 2 A Adequate and e; Criteria	2 835			3/15/23
	-	r determining adequate and criteria for determining er care include:				

Minnesota Department of Health

STATE FORM YR5J11 If continuation sheet 5 of 23

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´´	E CONSTRUCTION	COMPLETED	
		00501	B. WING		02/1	; 6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CENT	FR	IOND AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.)	D BE	(X5) COMPLETE DATE
2 835	Continued From page	ge 5	2 835			
	Evidence of adequa	ite care and kind and ent at all times. Privacy must				
	by: Based on observation review, the facility fa	ent is not met as evidenced on, interview, and document ailed to provide routine re for 1 of 2 residents (R138), er care; who had an indwelling of for infection, and had a act infections (UTIs).		Corrected		
	Findings include:					
		printed on 2/16/23, indicated to facility on 10/31/22.				
	consisted of infection due to indwelling ur infection, mild cognitive prostatic hyperplasi	tion of urine, and chronic				
	(MDS) assessment R138 having intact staff for toileting and	hange minimum data set , dated 12/21/22, identified cognition, required assist of 1 d personal hygiene, had an and a diagnosis of urinary				
	on 2/16/23, indicate month every evening ending on the 3rd ending to change catheter	der summary report, printed d foley catheter change every g shift starting on the 3rd and very month, for protocol nurse every month and as needed if ng, record number of cc's				

Minnesota Department of Health

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AND PLAN OF CORRECTION INTERPRETATION NUMBER:		,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	00501	B. WING		C 02/16/2023		
NAME OF PROVIDER OR SUPPLIER	1415 ALM	ORESS, CITY, S	TATE, ZIP CODE <b>E</b>			
LYNGBLOMSTEN CARE CENTE	<b>ER</b>	UL, MN 5510				
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE		
inserted; foley cathetemorning every Mondaleg and bed bags eveneeded when leaking Doxazosin Mesylate pressure and urinary enlarge prostate table bedtime for BPH relative hyperplasia with lower R138's care plan, pring R138 had self-care didecline in loss of functions assist with dressing, urinary retention due tract symptoms and or required staff to change more often if needed becoming full, ensuring draining freely, to rinsvinegar per protocol; protocol; staff to obseich aracter of the urine odor; assist with toile skin condition.  Review of record indicatheter in place priodiagnosed with UTI wompleted antibiotic to monthly foley catheter 11/9/22, 12/3/22, 1/14 culture was obtained symptoms of burning R138, urine culture we Review of nursing as	ecord size of french catheter fer bag changes in the ay for protocol, staff changes ery week on bath day and as g; (used to treat high blood problems caused by an et), Give 2 mg by mouth at ated to benign prostatic er urinary tract symptoms.  Inted on 2/16/23, indicated leficit related to recent ction and required 1 staff to grooming, bathing; had to BPH with lower urinary chronic foley catheter use, age catheter bag weekly, ge bag at least every shift, to keep the bag from any no kinks and urine is see out catheter bags with maintain foley catheter per erve/report changes in es such as color, clarity and eting cares and monitoring icated R138 had foley or to facility admission, while admitted to facility and therapy on 11/1/22, had er changes per staff on 4/23, and 2/5/23. A urine on 2/5/23 due to bladder g with urination reported per	2 835				

Minnesota Department of Health

STATE FORM YR5J11 If continuation sheet 7 of 23

Minnesota Department of Health

AND PLAN OF CORRECTION INTERCATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00501	B. WING		C 02/16/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LVNCDI	OMOTENI CADE CENT	1415 ALN	IOND AVENU	IE .		
LYNGBL	OMSTEN CARE CENT	SAINT PA	UL, MN 5510	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
2 835	Continued From pa	ge 7	2 835			
	foley catheter cares R138's catheter bay document/update n remember to rinse vinegar per protoco Review of NA-E's, N	urse with outputs, staff to R138's catheter bags with l.  NA clinical skill				
	competency-annual performance review, dated 12/19/22, indicated NA-E met competency to wash residents daily so resident is clean and odor free, demonstrated peri-care provided correctly using infection control technique, demonstrated catheter care correctly					
	skin daily with cares	e/clean), observes resident s and documents findings, and d individualized toileting plan.				
	at 7:35 a.m., NA-E prior to entering R1 care. NA-E placed hands, took night be located behind R13 bag tubing from planight bag with alcohand emptied into gr	noted to use hand sanitizer 38's room to perform catheter a pair of clean gloves on ag out of covering holder 8's wheelchair, removed, night stic holder, cleansed end tip of hol wipe, released lock on bag aduated cylinder, locked night				
	placed back into placed night bag back wheelchair, took grainto R138's bathroorinsed cylinder with water from graduate toilet, placed graduate toilet, removed glov can, washed hands sink, grabbed pape threw paper towel in	wiped end tip of night bag, astic holder of night bag, ack into covering holder behind aduated cylinder with urine m, emptied urine into toilet, water from sink, emptied ed cylinder into toilet, flushed ated cylinder on ledge behind res and placed into garbage with soap/water at bathroom r towels to dry hands and nto garbage can. NA-E was empleted peri-care/foley				

Minnesota Department of Health

STATE FORM YR5J11 If continuation sheet 8 of 23

Minnesota Department of Health

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMPLETED
	00501	B. WING		C <b>02/16/2023</b>
NAME OF PROVIDER OR SUP	PLIER STREET A	DDRESS, CITY, S	STATE, ZIP CODE	
LYNGBLOMSTEN CARE	CENTER	MOND AVENU AUL, MN 5510		
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
2 835 Continued Fro	m page 8	2 835		
catheter care observation, N catheter care routine morning peri-care/foley provided, NA-provided for F movement (B rectal area on care/foley catheter care was not stated when care care/foley listed switching urinary bag where we will be care/catheter the facility, deat time when stated when catheter care nursing compliant indicated away needs, had not catheter care nursing compliant indicated away needs, while interview indicated away needs, had not catheter care nursing compliant indicated away needs, while interview indicated away needs, while in	er that morning, as peri-care/foley not completed at time of IA-E responded peri-care/foley had not been completed during ag cares. NA-E was asked when catheter care was typically E responded peri-care was 138 after R138 had a bowel W) earlier that morning, cleansing by. NA-E stated routine perineter care was completed on r days and per R138's request, d routine peri care/foley catheter completed on a daily basis. NA-E etermining residents' care needs, the daily NA care sheet, and 8's care sheet did not list for catheter care to be provided, only g of urinary bags, cleansing used th vinegar solution, emptying uring shift as needed and recording. During conversation with NA-E, I staff do not routinely provide perinare, stated he had a UTI while in nied having any urinary symptoms asked.  Wed, on 2/16/23 at 8:58 a.m., NA-F reness of R138's catheter care of provided routine peri care/foley in past for R138, stated licensed eted due to risk for infections with			

Minnesota Department of Health

STATE FORM YR5J11 If continuation sheet 9 of 23

Minnesota Department of Health

AND BLAN OF CORRECTION INTERCATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
0050	)1	B. WING		<b>02/1</b>	; 6/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	
		IOND AVENU	•		
LYNGBLOMSTEN CARE CENTER	SAINT PA	UL, MN 551	08		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE PREGULATORY OR LSC IDENTIFY)	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 835 Continued From page 9		2 835			
night for all residents, license with NA's towards end of shift completed. LPN-C indicated care/catheter cares should be no special circumstances for to complete per LPN-C knowl.  While interviewed, on 2/16/23 director of nursing (DON) indireceive training to provide roucare/catheter care upon hire, needed (PRN), NA's complete off by licensed nursing. The I were able and expected to procare/catheter care for all residemorning and bedtime cares, a needed. The DON indicated not need to indicate NA's are peri care/catheter care for ear providing routine peri care/catheter care for ear providing routine peri care/catheter.  Facility policy titled Catheter of Drainage and Leg Bag, revise received, did not indicate providing routine catheter in policy titled Catheter in policy titled Catheter of Drainage and Leg Bag, revise received, did not indicate providing routine gatheter in policy titled Catheter in policy titled Catheter of Drainage and Leg Bag, revise received, did not indicate providing routine gatheter in policy titled Catheter in policy	to ensure task R138's peri completed by NAs, only licensed nurse edge.  at 10:52 a.m., the cated all NA's itine peri yearly, and as e a checklist signed DON stated all NA's ovide routine peri dents during as well as whenever NA care sheets did to complete routine ch resident, as theter care was a in to all nursing  Care- Urinary ed date 6/22, was vision of peri care acy/procedure.  CORRECTION: ignee, could review its with catheters to as ordered. The e, could conduct opriate care and s ordered. The e taken to the QAPI mount of time to				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '			OMPLETED	
		00501	B. WING		02/1	; 6/2023	
	PROVIDER OR SUPPLIER	1415 ALM	OND AVENU				
LINOBL	OMOTEN OAKE OEN	SAINT PA	UL, MN 551	08			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 835	Continued From pa	ge 10	2 835				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 995	MN Rule 4658.0610 Requirements -Gro	Subp. 3 Dietary Staff oming.	2 995			3/15/23	
	Subp. 3. Grooming. Dietary staff must wear clean outer garments. Hairnets or other hair restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint.						
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to label, date opened containers of food stored, ensure expired food were identified and removed from walk-in produce refrigerator and dry good storage room. Furthermore, the facility failed to ensure food was served under sanitary conditions, proper sanitization of thermometer when temping foods; and failed to ensure dishes and food preparation equipment were appropriately air dried. This had the potential to affect all 211 residents who were served food and beverages from the facility kitchen.			Corrected			
	Findings include:						
	2/13/22 at 2:10 p.m manager (CDM)-A, walk-in produce refuthat were not dated expired. CDM-A in	d observation of kitchen on , with certified dietary observed food items in the rigerator and dry goods room or marked and/or were dicated food production ypically went through all food					

Minnesota Department of Health

STATE FORM YR5J11 If continuation sheet 11 of 23

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE SAINT PAUL, MN 55108  CX4) ID PROVIDER'S PLAN OF CORRECTION  EACH EMPTION MISS THE PRECEDED BY FULL TAG  CROSS-REFERENCE OF CONTEST OF THE CONTEST ON THE CONTEST OF THE CONTEST ON THE CONTEST OF THE CONTEST OF THE CONTEST ON THE CONTEST OF THE CONTEST ON THE CONT		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMP	SURVEY
Author   Care Center   Salan Paul   Month			00501	B. WING		1	
CANDESTENCARE CENTER   SAINT PAUL, MN 55108	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  2 995  Continued From page 11 inventory twice weekly, checking food for opened dates and expiration dates, removing food when expired. CDM-A stated all kitchen staff should be checking food for opened dates and expiration dates, removing when expired as well. CDM-A indicated all left-over prepared food and beverages when marked were good for 3-7 days from date opened, depending upon product and per facility policy.  The following items were observed during tour:  Walk-in produce refrigerator:  1. Small cubed pineapple fruit in facility container; approximately ½ full, opened date 2/1/23; no expiration date; dried out, foul odor  2. 4 bags of lettuce in original package; unopened, unmarked/undated, no expiration date; lettuce wet with occasional brown discoloration  3. Cut up celery sticks sealed in zip-lock facility bag; approximately ½ full, dated 2/11/23; celery stalk wet with brown discoloration at ends  4. Carrot sticks sealed in zip-lock facility bag; approximately ½ full, unmarked/undated; no expiration date; dried out/shriveling  During an observation with CDM-A, on 2/13/23 at 2:48 p.m., noted dietary aide (DA)-Z remove wet trays from dishwasher, wet trays placed into top tier of stand-up drying rack, water from wet trays dripped downwards onto open rack containing clean/air dried plastic food storage container lids.  3 plastic food storage container lids were stacked one on top of the other, top plastic food storage container lid had several white, dried	LYNGBL	OMSTEN CARE CENT	ΓER				
inventory twice weekly, checking food for opened dates and expiration dates, removing food when expired. CDM-A stated all kitchen staff should be checking food for opened dates and expiration dates, removing when expired as well. CDM-A indicated all left-over prepared food and beverages when marked were good for 3-7 days from date opened, depending upon product and per facility policy.  The following items were observed during tour:  Walk-in produce refrigerator:  1. Small cubed pineapple fruit in facility container; approximately ¾ full, opened date 2/7/23; no expiration date; dried out, foul odor  2. 4 bags of lettuce in original package; unopened; unmarked/undated; no expiration date; lettuce wet with occasional brown discoloration  3. Cut up celery sticks sealed in zip-lock facility bag; approximately ½ full, dated 2/11/23; celery stalk wet with brown discoloration at ends  4. Carrot sticks sealed in zip-lock facility bag; approximately ½ full, unmarked/undated; no expiration date; dried out/shriveling  During an observation with CDM-A, on 2/13/23 at 2:48 p.m., noted dietary aide (DA)-Z remove wet trays from dishwasher, wet trays placed into top tier of stand-up drying rack, water from wet trays dripped downwards onto open rack containing clean/air dried plastic food storage container lids.  3 plastic food storage container lids.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
During an observation with CDM-A, on 2/15/23 at 10:35 a.m., DA-A removed pan of skewered	2 995	inventory twice weed dates and expiration expired. CDM-A star checking food for or dates, removing whindicated all left-over beverages when make from date opened, oper facility policy.  The following items  Walk-in produce reform the followin	ekly, checking food for opened in dates, removing food when ated all kitchen staff should be pened dates and expiration iten expired as well. CDM-A er prepared food and arked were good for 3-7 days depending upon product and were observed during tour:  frigerator: eapple fruit in facility container; ll, opened date 2/7/23; no ed out, foul odor in original package; ed/undated; no expiration th occasional brown  cks sealed in zip-lock facility 1/2 full, dated 2/11/23; celery in discoloration at ends led in zip-lock facility bag; ll; unmarked/undated; no ed out/shriveling  from with CDM-A, on 2/13/23 at early aide (DA)-Z remove wether, wet trays placed into toping rack, water from wet trays is onto open rack containing tic food storage container lids. Ge container lids were of the other, top plastic food d had several white, dried abled water spots.				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00501	B. WING	_	l	C <b>16/2023</b>
	PROVIDER OR SUPPLIER	1415 ALM	DRESS, CITY, STOND AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 995	grabbed thermome removed plastic cap inserted tip of therm to temp shrimp, remshrimp, alcohol wip thermometer down.  When interviewed, CDM-A indicated was were delivered to faitems, place older for newer food items to be used up food items were op when opened so stadiscard items if bey date. CDM-A indicated items if bey date. CDM-A indicated fresh produce daily discolored, had incomplished insertion of food who when opened so stadiscard items if bey date. CDM-A indicated would be a insertion of food who when interviewed, CDM-A indicated would be a insertion of food who when interviewed, CDM-A indicated allowed insertion of food who when interviewed, CDM-A indicated would be a insertion of food who when interviewed, CDM-A indicated allowed with a insertion of food who when interviewed, CDM-A indicated allowed in the prior to and after insertion of food who when interviewed, CDM-A indicated allowed in the prior to and after insertion of food who when interviewed, CDM-A indicated allowed in the prior to and after insertion of food who when interviewed, CDM-A indicated allowed in the prior to and after insertion of food who when interviewed, CDM-A indicated allowed in the prior to and after insertion of food who when interviewed, CDM-A indicated would increase the prior to and after insertion of food who when interviewed, CDM-A indicated allowed in the prior to and after insertion of food who when interviewed, CDM-A indicated would increase the prior to and after insertion of food who when it is a prior to an after insertion of food who when it is a prior to an after insertion of food who who when it is a prior to an after insertion of food who who when it is a prior to an after insertion of food who who who who who who when it is a prior to an after insertion of food who	set pan on food prep table, ter from kitchen drawer, of from tip of thermometer, nometer into skewered shrimp noved thermometer from ed tip of thermometer, set on food prep table.  on 2/13/23 at 2:10 p.m., hen food and beverage items acility, staff would rotate food ood items towards the front, owards the back, older food of first. CDM-A stated when ened, staff were to mark date aff would be aware of when to ond facility policy expiration ated staff should be checking, if food appeared dry, reased moisture, or was foul all be discarded immediately.  I, on 2/15/23 at 10:41 a.m., all typically cleanse tip of lcohol wipe prior to and after the temping food.  on 2/15/23 at 10:47 a.m., I staff temping food should be remometer with alcohol wipe	2 995			

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Minnesota Department of Health

AND PLAN OF CORRECTION INTERCATION NUMBER:		1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00501	B. WING		C 02/16/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LVNCDI	OMOTENI CADE CENT	1415 ALM	OND AVENU	JE		
LYNGBL	OMSTEN CARE CENT	SAINT PA	UL, MN 551	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE	
2 995	Continued From pa	ge 13	2 995			
	consumed by their s	safe use dates, or frozen, or				
	Dating of Food, revior; food items store and freezer will be of the cooks and dietal proper rotation, all f within 48-72 hours. Production Manage freezer for uncoveredue when major orderedue when must be allow before being stacked items such as pans and may allow an emicroorganisms can equipment food-constall be cleaned: be type of raw animal flamb, pork, or POU change from working with READY-TO-EA with raw fruits and working with READY-TO-EA with raw fruits and working the READY-TO-EA with raw fruits and working with READY-TO-EA with raw fruits and working wor	22, clean EQUIPMENT, NENS; and unwrapped and SINGLE-USE ARTICLES. It and Utensils, Air-Drying wed to drain and to air-dry ed or stored. Stacking wet prevents them from drying nvironment where he begin to grow. 4-602.11 ontact Surfaces and Utensils. Intact surfaces and utensils efore each use with a different FOOD such as beef, FISH, LTRY; Each time there is a hig with raw FOODS to working AT FOODS; Between uses regetables and with URE CONTROL FOR SAFETY gor storing a FOOD EASURING DEVICE; At any				
	TEMPERATURE M	EASURING DEVICE; At any ration when contamination				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00501	B. WING			C 1 <b>6/2023</b>
	PROVIDER OR SUPPLIER	TER 1415 ALM	DRESS, CITY, S IOND AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 995	The dietary manage administrator, could control technique is The facility could all storage occurs and under sanitary condupdate or create poeducate staff on the competencies. The dietician, or administration periodically to ensure should report audit Performance Improrecommendations a	THOD OF CORRECTION: er, registered dietician, or densure appropriate infection maintained in the kitchen. so ensure appropriate food dishware/utensils are dried ditions. The facility could elicies and procedures, and ese changes and perform dietary manager, registered estrator could perform audits re compliance. The facility findings to Quality Assurance evement (QAPI) for further and to determine compliance.  R CORRECTION: Twenty-one	2 995			
21385	Staff assistance  Subp. 3. Staff assistance Personnel must be infection control protection control protection and protection control program.  This MN Requirements by: Based on observation review the facility farmed medicare and Medicare a	istance with infection control. assigned to assist with the ogram, based on the needs of ursing home, to implement ocedures of the infection  ent is not met as evidenced on, interview, and document ailed to follow Centers for caid Services (CMS) and the Control (CDC) guidelines to of Covid-19, when during a and high Covid-19 community	21385	Corrected		3/15/23

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AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00501	B. WING		02/1	6/2023
	PROVIDER OR SUPPLIER  OMSTEN CARE CENT	1415 ALN	MOND AVENU			
		SAINT PA	AUL, MN 551	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 15	21385			
	observed not wearing protective equipment	ents, visitors and staff wereing appropriate personal nt (PPE), specifically masks. ial to affect all 211 residents facility.				
	Findings include:					
	who was admitted of Covid-19 on 2/7/23, based precautions.	outbreak status when R307, on 2/3/23, tested positive for and was in transmission In addition, the county ssion level for Covid-19 was				
	observed two signs facility regarding viswere on the door as facility. Both signs vicredenza inside the the receptionists destop and look for the them. The two signs ATTENTION VISITED to the Care Center complete a Covid-1 temperature check However, we ask the you are experiencing the following: tested 10 days, have Covid close contact with a the last 10 days. Curvear face coverings residents as the Covin the surrounding of					
		ion on 2/13/23, at 3:45 p.m., a name a wall entering the TCU				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE SAINT PAUL, MN 55108   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  Continued From page 16 (transitional care unit) on first floor. The sign dated 11/29/22, had a large red stop sign followed by: All Staff and Volunteers MUST wear a face	(X5) COMPLETE DATE
NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE SAINT PAUL, MN 55108   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  Continued From page 16  (transitional care unit) on first floor. The sign dated 11/29/22, had a large red stop sign followed by: All Staff and Volunteers MUST wear a face	(X5) COMPLETE
CAMPAGE CENTER   SAINT PAUL, MN 55108	COMPLETE
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21385 Continued From page 16 (transitional care unit) on first floor. The sign dated 11/29/22, had a large red stop sign followed by: All Staff and Volunteers MUST wear a face	COMPLETE
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  21385  Continued From page 16  (transitional care unit) on first floor. The sign dated 11/29/22, had a large red stop sign followed by: All Staff and Volunteers MUST wear a face	COMPLETE
(transitional care unit) on first floor. The sign dated 11/29/22, had a large red stop sign followed by: All Staff and Volunteers MUST wear a face	
dated 11/29/22, had a large red stop sign followed by: All Staff and Volunteers MUST wear a face	
mask while in a resident care area. Visitors are strongly encouraged to wear face masks as well.  During an interview on 2/14/23, at 2:40 p.m., the assistant director of nursing (ADON)-E was informed of observations of visitors entering the facility, walking past the reception desk and getting on an elevator without masking.  Discussed the location of the signs, (laying flat on surfaces), the content of the signs not being easily processed by people as they entered the facility. The ADON-E stated she was aware of the CDC and CMS guidance for visitor masking, but interpreted it as being optional.  During an interview and observation on 2/15/23, at 10:29 a.m., the ADON-E was asked to observe three visitors by fireplace/elevators sitting in a	
grouping of chairs. None had masks on. While these individuals were not in a resident care area at that time, they had walked a distance into the facility without donning masks. The ADON-E stated it was a visitors choice not to wear a mask. The ADON-E acknowledged the Covid-19 community transmission rate was high and the facility was in Covid-19 outbreak status.	
Observations and interviews of RESIDENT masking: On 2/15/23, at 10:30 a.m., 14 unmasked residents (R130, R148, R163, R255, R101, R85, R126, R65, R32, R49, R131, R26, R129, R119) were observed attending live music by a singer on third floor. The activity lasted from 10:30 a.m. to 11:20 a.m.  On 2/15/23, at 11:29 a.m., therapy coordinator	

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> ` ´	E CONSTRUCTION	COMPLETED		
		00501	B. WING		02/1	; 6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CENT	ΓER	OND AVENUUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 17	21385			
	recommended for a encourage resident	ent masking had not been while, adding she did not s to wear a mask as she had was required for residentsit for staff.				
	masking was a choose than mandatory and resident, as some of was needed. TC-B residents if they was consistently. TC-B s	:47 (TC)-B stated she thought ice for the residents rather I that it depended on the lid not understand why a mask stated she sometimes asked nted a mask, but did not do it stated she had not heard the l-19 outbreak status.				
	a wheelchair, self phallway near the direction need to wear a mass staff encouraged he outside of her room tell us to unless we'll According to quarte	2 p.m., R101 was who was in ropelling in her third floor ning room stated, "We don't sk anymore." When asked if er to wear a mask when a R101 replied, no, "They don't re going to the doctor." orly Minimum Data Set (MDS) 11/9/22, R101 was cognitively				
	her recliner watchin knew if residents no out of their room an that, or had staff as outside of her room	52 p.m., R56 was resting in g TV. R56 was asked if she eded to wear masks when d replied no one had told her ked her to wear a mask a. According to admission MDS 1/15/23, R56 was cognitively				
	a resident hallway v floor, on her way to didn't think she had	40 p.m., R120 was walking in with her walker on second play cards. R120 stated she to wear a mask anymore and, ded me." According to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
	00501	B. WING			C 6/2023	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE  SAINT PAUL, MN 55108						
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
was cognitively inta  On 2/15/23, at 3: earlier on first floor mask on, and who laptop stated, "I we but not in the hallw told I need to." Acc assessment dated intact.  On 2/15/23, at 3: hallway on third floo side by side with R wheelchair. R53 wa R87's mask was be don't think we have tell me to." Accordi assessment dated intact.  On 2/16/23, at 8: (NA)-D on third floo required for resider room; masks were  Observations and i masking: On 2/14/23, at 3: (FM)-F was on four way to the coffee s she didn't think visi mask"No one has stated if she should On 2/15/23, at 2: unmasked was obs floor on his way to	essment dated 12/28/22, R120	21385				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE  COMP		SURVEY LETED	
		00501	B. WING		02/1	; 6/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CENT	FER	OND AVENU UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21385	Continued From pa	ge 19	21385			
	needed to but was i mask. FM-G visited	not opposed to wearing a R52 daily.				
	unmasked, was in to nurses station talking FM-H stated he had facility for quite awher him he should. FM-about 50% of the tire.  On 2/16/23, 9:03 receptionist (R)-I, which is it is masking, so to wear a mask if the visitor masking to be a property of the DON stated the ADO visitor and resident they would do a little masks, adding they residents, but could The DON was infortal to the poon wa	he hallway on third floor at the ng to nursing assistant (NA)-D. If not worn a mask in the nileadding no one had told H stated he wore a mask me when he came to to visit.  a.m., main entrance then asked what her role was stated she encouraged visitors be asked, but understood e optional.  on 2/16/23, at 9:44 a.m., the ON-E had talked to him about masking. The DON stated e more to ask people to wear encouraged visitors and n't force them to wear masks. The med of observations and ents and visitors without				
	ADON-E was informinterviews of resider masks. The ADON-interpreted the CDO masking was not masking transmission. Covid-19 had been residents didn't wan adding many stopped and they could see	on 2/16/23, at 10:43 a.m., the ned of observations and ints and visitors without E stated the way she and CMS guidelines, andatory, even during status and during high sion. The ADON-E stated going on a long time and it to wear masks anymore, ed taking Covid-19 boosters residents were sick and tired ADON-E stated she had not				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1415 AL MOND AVENUE SAINT PAUL, MN 55108    CACH DEPRICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREPIX TAG
NAME OF PROVIDER OR SUPPLIER  LYNGBLOMSTEN CARE CENTER  SITREET ADDRESS, CITY, STATE, ZIP CODE  1415 ALMOND AVENUE SAINT PAUL, MN 55108  (24) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  CROSS-REFERENCE TO THE APPROPRIATE  DEFICIENCY)  21385  Continued From page 20  re-educated residents on wearing masks and didn't know if anyone else had. The ADDN-E admitted in her role, she would likely be the one to bring up re-education to the leadership team. The ADDN-E could not recall when residents and visitors stopped wearing masks, but thought it was last fall.  Discussed using the care plan to identify residents who were not able to or did not want to wear a mask, as there wasn't currently a way for staff to identify those residents from residents who wanted to be reminded to wear a mask.  During an interview on 2/16/23, at 11:05 a.m., the ADDN-E stated the facility did not have a policy specific to resident masking.  During an interview on 2/16/23, at 11:33 a.m., (ADDN)-D who attended resident council meetings stated they had not done any recent re-education for residents on masking.  Observations and interviews of STAFF masking. On 2/14/23, at 2:43 p.m. observed trained medication aide (TMA)-A on second floor without a mask. TMA-A indicated entered the facility's back entrance when arrived to work and masks
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EVAIL   DESCRIPTION   SAINT PAUL, MN 55108   PROVIDER'S PLAN OF CORRECTION   CALL   DESCRIPTION   PROVIDER'S PLAN OF CORRECTION   CALL   DESCRIPTION   PREFIX   TAG   (EACH DETICINCY MUST BE PRECEDED BY PULL   PREFIX   TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   DATE    21385   Continued From page 20   21385   Continued From page 20   21385   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   DATE    21385   Continued From page 20   21385   PROVIDER'S PLAN OF CORS-REFERENCED TO THE APPROPRIATE   DATE    21385   Continued From page 20   21385   PROVIDER'S PROPRIATE   DATE    21386   PROVIDER'S PROPRIATE   DATE   DATE    21385   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   DATE    21385   CONTINUED STATE   DATE   DATE   DATE    21385   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    21385   CONTINUED STATE   DATE   DATE   DATE    21385   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    21385   CONTINUED STATE   DATE   DATE    21385   CONTINUED STATE   DATE   DATE    21385   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE    21385   CROSS-REFERENCED TO THE APPROPRIATE    2138
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stated masks were not available until arrived to second floor. TMA-A confirmed entered room 214 to obtain a mask, and stated was expected to enter the room or the facility with PPE.  On 2/15/23, at 3:30 p.m. during an interview the DON indicated staff were expected to wear a mask immediately entering the building,  On 2/15/23, at 3:37 p.m. during an interview assistant director of nursing (ADON)-E stated

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AND PLAN OF CORRECTION INTERPRETATION NUMBER:		<b>l</b> ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00501	B. WING		C 02/16/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
LYNGBL	OMSTEN CARE CENT	ΓER	OND AVENU UL, MN 551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
21385	unavailable to staff entrance.  Facility policy titled Guidelines, with revindicated the purporthe prevention of Cominimize exposures. The Care Center were CDC and CMS web information and resignidance for visitating CMS Memorandum. The facility would uncovering or masking reduce the risk of Cogiven source control to protect staff and transmission of potential pathogen worn by all staff at a areas. Staff could not access their moundrink). Staff should safe distance for other contain all components of the contain	and confirmed masks were at the back employee  Covid-19 Infection Control rised date of 2/13/2023, see was to provide guidance on ovid-19 and to prevent and set to respiratory pathogens. Tould regularly monitor the ources, and would adhere to on detailed within revised a QSO 20-39 dated 9/23/22. It core principles of face gwhen permitting visitation to covid-19 and visitors would be of facemasks. PPE was used residents from the entially dangerous and/or as. Face masks would be all times when in resident care nomentarily lower their mask withs as needed (e.g. to take a only lower their mask when a thers (e.g. 6 feet).  CHOD OF CORRECTION: The tursing) or designee could ypolicies to ensure they ents of an infection control transmission of potential N or designee could educate or revised policies are being its of those audits could be surance Performance nittee to determine compliance	21385		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVI	
		00501	B. WING		C 02/16/20	23
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NAME OF I	PROVIDER OR SUPPLIER		MOND AVENU	STATE, ZIP CODE		
LYNGBL	OMSTEN CARE CENT	IFR	AUL, MN 551			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CON	MPLETE DATE
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∠1365		ge 22 rrection: Twenty-one (21)	21300			

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