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

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:

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

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245347	A. BUILDING ______ B. WING ______	C 02/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/13/23-2/16/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/13/23-2/16/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: H53478496C(MN00090965), H53478209C(MN00083852), H53478208C(MN00085747), H53478207C(MN00087959), and H53478206C(MN00090679). The following complaints were reviewed: H53478214C (MN00090860) with a deficiency issued at F609 and F610. The facility's plan of correction (POC) will serve as your allegation of compliance upon the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/15/2023

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.

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F 000	Continued From page 1 Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		3/24/23

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F 609

Continued From page 2

Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to immediately report to the administrator and no later than 2 hours, to the State Agency (SA), in accordance with established policies and procedures, an allegation of staff to resident verbal abuse and an allegation of resident to resident abuse for 2 of 2 residents (R27, R192) who was reviewed for allegations of abuse.

Findings include:

R27's diagnoses report printed on 2/15/23, included dementia, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or inability to move on one side of the body) following cardiovascular disease affecting his right dominant side.

R27's quarterly Minimum Data Set (MDS) assessment dated 11/20/22, indicated R27 was cognitively intact, had adequate vision and hearing, clear speech, was understood and could understand. R27 required extensive assistance of one staff for most ADL's (activities of daily living) and did not walk.

R27's care plan created on 8/12/22, indicated R27 had an alteration in ability to remove self from harm due to hemiplegia and hemiparesis of right side due to cerebral infarction (stroke).

Progress notes in R27's electronic medical record (EMR) indicated:

F 609

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:

F609
It is the policy of Lyngblomsten that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials. To assure continued compliance the following plan has been implemented:
Regarding cited residents:
With respect to resident R27, the incident referenced was reported by nursing administration when additional information was reported by the state surveyor on

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--2/10/2023, at 5:35 p.m., note entered by social services (SS)-A:
Nursing assistant (NA)-C told writer that family member (FM)-C just told her R27's roommate, R162 - "threatened him" while she was visiting. FM-C had left. Writer spoke with R27. R27 stated R162 told him he would "kill him" and "punch him in the face". Writer asked R27 what precipitated this and R27 said they do not like each other because they both think the other one makes too much noise. Writer has offered ear plugs in the past and both have declined. R27 then stated R162 also threatened FM-C. Writer spoke with roommate R162 who stated he did say he would kill R27 but did not say he would punch him the face and only threatened R27. R162 stated he would not actually harm R27 and that he is "verbally aggressive but not physically aggressive." Writer asked R27 if he was scared or fearful to which he answered "no". Writer asked if he felt safe staying in the same room as his roommate this weekend and he stated he did. He stated that if R162 were to punch him, he would stomp on his foot in return. Nurse on shift and house supervisor notified. R27 is on private room waiting list. SS to continue to assist PRN (as needed).

--2/10/2023, at 6:37 p.m., note entered by licensed practice nurse (LPN)-B:
R27 reported to SS-A that roommate R162 threatened him this shift. R27 stated that they have had issues in the past about noise and the same continues. R27 told this writer, he spoke to SS-A about the ongoing noise issue and was aware he is on the waiting list for a room. Will continue to monitor the roommates per facility protocol.

F 609

2-13-23. Resident R27 was moved to a different room and neighborhood and assessed by the house psychologist for psychosocial harm and found to be not distressed and comfortable in his new room. Results of internal investigation substantiated allegation of resident to resident abuse as R27 endorsed feeling threatened to the state surveyor. With respect to R192, the resident was assessed for harm following her reports of rough treatment and verbal abuse by staff. Resident reported that the rough treatment and verbal abuse was witnessed by two staff members, interviews with both staff members does not support residents report. Resident has been observed and has not demonstrated any changes to her mood or behavior that indicates effects from the allegation. Resident care plan has been updated to reflect approaches and preferred caregivers to prevent future occurrences. Resident is scheduled to transfer to long term care section of the building.
Actions taken to identify other potential residents having similar occurrences:
Vulnerable adult reporting requirements have been reviewed with all appropriate staff, with staff demonstrating compliance with their respective reporting responsibilities. Facility administration has implemented a communication, documentation, and review process for all potential vulnerable adult abuse or neglect allegations to ensure those requiring reporting to the SA are done so appropriately.

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F 609	Continued From page 4 During an interview on 2/13/23, 2:48 p.m., R27 stated, "I have a terrible roommate, he keeps me up all night." R27 stated his roommate, R162, yelled and screamed due to his sore diabetic foot. R27 then stated R162 had threatened FM-C, saying "I'll get you too." From R27's room, FM-C was contacted via telephone. FM-C stated she had been at the facility the afternoon of 2/10/23, visiting R27. FM-C stated R162 had not been in the room when she arrived. When R162 did arrive to the room, he made loud sounds - described by FM-C as involuntary sounds that made her jump. When that happened, R27 said out loud that R162 did that all the time, which seemed to set off R162. With a urinal in hand, R162 walked to R27's side of the room where both FM-C and R27 were sitting and stated, "you SOB (son of a bitch) I could kill you." FM-C stated R162 had been so angry she thought he was going to throw urine at them. FM-C stated despite the raised voices, no staff came in to see what was going on. FM-C stated R162 called her and R27 names including boar head and stated, "I could just kill you." FM-C stated, "I felt sick to my stomach," adding it was so unexpected. FM-C stated she was very concerned about R27 and on her way out of the facility at approximately 3:15 p.m. talked to a nursing assistant (NA) whose name she did not know. FM-C told the NA that R162 had been very upsetting and told her what R162 had said to her and R27. The NA replied, oh they do this. FM-C stated she told the NA, that R162 was not joking; that he had been abusive to both her and R27, informing the NA it had been very upsetting. With telephone call to FM-C concluded, R27 stated one of the aids had witnessed this behavior in the past, but did not know her name. When asked how this incident made him feel, R27 stated he supposed R162	F 609	Measures put in place to ensure deficient practice does not occur: Facility reviewed the VA policy and facility guidance for reporting and investigations, no revisions were made, however a secondary process was developed to communicate, document, and review all potential abuse and neglect allegations. Utilizing the facility online learning portal, education was developed that reviews the reporting requirements for each staffs' respective responsibilities. Effective implementation of actions will be monitored by: Nursing Administration will review all allegations of abuse, neglect, exploitation or mistreatment for proper reporting. Nursing Administration will conduct random knowledge audits of nursing staff, completing 3 audits per week for 1 month, then 1 audit per week for 2 months. Findings will be reported to Director of Nursing and Administrator. Those responsible to maintain compliance will be: The Director of Nursing and/or designee will audit the data collected which will be presented and discussed monthly at the Quality Assurance Committee meetings. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions. Completion date for certification purposes only is 3-24-23	

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F 609	Continued From page 5	F 609		

could hurt him if he snuck up on him, adding if he had to, he could hit R162 with his pick-up stick, pointing to his orthopedic reacher-grabber. R27 stated he had to keep his mouth shut when around R162 so R162 didn't start yelling at him.

On 2/13/23, at 3:16 p.m., in the director of nursing (DON) office, both the DON and assistant DON (ADON)-D where informed of the specifics of the allegation of verbal abuse as told by R27 and FM-C.

On 2/13/23, at 3:27 p.m., the DON stated he had been informed of the incident via telephone by registered nurse (RN)-E on 2/10/23, at 5:04 p.m. The DON stated he did not feel harm had resulted from the verbal altercation, therefore the incident had not been reported to the SA. The DON stated R162 had admitted to staff he had been verbally aggressive toward R27 and FM-C, but would never harm R27. R27 had told SS-A he was not afraid of R162 and felt safe. The DON stated he felt R27 had dramatized the incident for the State surveyor.

On 2/13/23, at 4:37 p.m., the DON informed surveyor that the incident would be reported to the SA, adding he felt the surveyor had given the facility information they did not initially have.

During an interview on 2/14/23, at 2:51 p.m., SS-A stated NA-C had talked to her after incident on 2/10/22, in the "late afternoon." NA-C told SS-A that R27 and R162 were not getting along; that R162 said something to R27 that upset him. SS-A stated she then talked to R27 and R162 separately in their room. When she asked R27 if everything was going okay, R27 replied that R162 needed to live in the basement with the rats. R27

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informed SS-A that R162 said, I will kill you and punch you in he face. When asked what caused the incident, R27 told SS-A, the two did not get along and that R162 was too loud. SS-A stated both residents had been offered ear plugs in the past. Following the interview with R27 and R162, SS-A informed RN-E who stated she would call FM-C and the DON. SS-A stated since R27 told her he felt safe, was not scared or fearful, was comfortable staying in his room and would stomp on R162's foot if R162 came after him, the two residents had not been separated.

During an interview on 2/14/23, at 3:00 p.m., NA-C stated FM-C had come to her on 2/10/23, complaining that R162 and R27 argued a lot and she felt R162 had been bullying R27. FM-C told NA-C that R162 said he was going to kill R27. NA-C said she told FM-C that the two men joked around a lot, that R162 didn't mean it, and told FM-C she would let the nurse know. NA-C stated she informed both licensed practical nurse (LPN)-B and SS-A what FM-C told her. When asked if she had heard the two men argue in the past, NA-C stated the two interacted a lot with each other, but she had not heard them argue...just joke around.

During a telephone interview on 2/15/23, at 10:49 a.m., LPN-B stated when NA-C informed her of the incident on 2/10/23, she spoke to R27 and R162 separately. Both residents complained to LPN-B about the noises each other made. R27 told her what happened when FM-C was there...that R162 threatened to kill them. When asked if R27 and R162 had gotten into altercations in the past, LPN-B stated, nothing big, no threats. LPN-B stated R162 who was new to the room was trying to adjust to R27 and R27

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 7 was trying to adjust to R162. LPN-B stated she spoke to SS-A who informed her she would let RN-E know about the incident. RN-E who on duty on 2/10/23, the evening shift, was not available for interview. During an interview on 2/16/23 at 10:05 a.m., the DON stated he relied on staff to provide him with accurate information in order to assess risk, harm and intent. The DON stated he still made the right decision (not to report to the SA) based upon the information he received on 2/10/23. The DON stated he considered the dynamics and personalities of residents when making decisions and while R162 made outrageous comments, he never acted on them and R27 stated he felt safe. During an interview on 2/16/23, at 11:00 a.m., the administrator stated she first learned of the 2/10/23, incident between R27 and R162 when it had been reported by the State surveyor on 2/13/23. The administrator stated the incident should have been reported to the SA within the time frame outlined in the facility policy on reporting allegations of abuse. The administrator stated the comments made by R162 to R27 should have been taken seriously; that it would be better to err on the side of caution and file a report with the SA. R192 R192's significant change Minimum Data Set (MDS) assessment dated 1/7/23, identified R192 had diagnosis which included anemia (a deficiency of red blood cells) and atrial fibrillation (A-fib) (a heart condition where blood doesn't flow as well as it should). MDS indicated R192 had intact cognition and required extensive	F 609		

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F 609		F 609		

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 R192 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. R192 stated a few weeks ago in the evening during cares nursing assistant (NA)-A became angry and cursed when he had to change R192's incontinent product. R192 stated when he turned 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 her NA-A would no longer work with her.

Review of facility reported incidents to the SA lacked documentation of the SA being notified of 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)-B had told him he was not allowed to work with R192 anymore because R192 had alleged that NA-A had been rough during cares.

During an interview on 2/15/23 at 8:45 a.m. RN-A 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 with R192 or reported the allegation of abuse to the SA because he thought it had already been reported.

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During an interview on 2/15/23, at 2:30 p.m. RN-B stated on 2/5/23, RN-C had told her R192 had stated NA-A had been rough with her during cares within the past few days. RN B stated she then talked with R192 who had confirmed NA-A had been rough with her during cares. RN-B stated she had reported the allegation of abuse to the DON and later that day or the next day RN-B told NA-A he was no longer allowed to work with R192. RN-B confirmed she had not reported the allegation of abuse to the SA.

During an interview on 2/15/23, at 3:03 p.m. RN-C stated she had heard of the allegation of abuse in report on 2/4/23. RN-C further stated she had not directly talked with R192 regarding the allegation of abuse. RN-C confirmed she had not reported the allegation of abuse to the SA.

During an interview on 2/15/23, at 3:08 p.m. licensed practical nurse (LPN)-A stated on 2/4/23, R192 had told her that NA-A became angry and had cursed when he came in to change R192's incontinent product. R192 further stated she was scared because NA-A was still working on her unit. LPN-A confirmed she had not reported the allegation of abuse to the SA.

During an interview on 2/15/23, at 11:30 a.m. director of nursing (DON) stated on 2/5/23, RN-A had notified him that R192 had a concern with NA-A. DON stated he was not aware of any allegation of abuse. DON stated on 2/6/23, he had talked with R192 and had determined the word rough didn't mean rough. and said he was not aware R192 had been afraid of NA-A. DON stated he had talked with NA-B who was in the room at the time of the alleged abuse and NA-B had not heard NA-A curse. DON further stated he

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did not feel this was a reportable event but if it had been an allegation of abuse his expectation would have been that it would have been reported immediately but no more than two hours after forming the suspicion of abuse.

Facility policy titled Vulnerable Adult / Abuse Prevention with revised date of 3/2022, indicated the facility would not tolerate any forms of abuse, including verbal abuse. Abuse was defined as willful, meaning the individual would have acted deliberately. Verbal Abuse referred to threats of harm or any repeated or malicious oral language that willfully included disparaging, humiliating and derogatory terms to residents or their families, or within their hearing distance, regardless of age, ability to comprehend, or disability. If an alleged violation had been identified and reported to the Administrator, DON, or designee, the facility must immediately report it and provide protection for the identified resident(s) prior to conducting the investigation of the alleged violation. In some situations, the facility may initially evaluate an occurrence to determine whether it meets the definition of an "alleged violation." Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to abuse. The administrator, DON, or designee would immediately report suspected abuse to the required state or local agencies according to the Vulnerable Adult Reporting to State Agencies and Law Enforcement Guidance Tool.

Facility policy titled Vulnerable Adult Reporting to State Agencies and Enforcement Guidance Tool, with revised date of 10/2019, indicated resident to

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F 609	Continued From page 11 resident altercations would be reported to the SA where the following two criteria were met: 1. The act was "willful" meaning the individual ' s actions were deliberate regardless of whether the individual intended to inflict injury or harm (an individual with cognitive impairment, can commit a willful act). 2. There was "harm", meaning the act resulted in the infliction of injury, unreasonable confinement, intimidation or punishment causing injury, pain, or mental anguish. Facility policy titled Resident to Resident Altercation with revised date of 10/2019, indicated it was the policy of the facility to protect residents/individuals and to maintain a safe living environment for all individuals residing there. Resident to resident altercation was defined as an incident involving a resident who willfully inflicts injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish upon another resident. Willful was defined as the individuals action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. Injury was defined as resultant physical harm, pain or mental anguish. The facility would implement interventions that addressed potential or actual negative interactions. Examples included eliminating or reducing underlying causes of distressed behaviors such as boredom or pain, monitoring environmental influences such as temperature, lighting and noise levels.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		3/24/23

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F 610	Continued From page 12 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a thorough investigation for a resident to resident altercation and to assure residents were safe and prevent further potential abuse by allowing the alleged perpetrator (AP) to continue to have access to other vulnerable adults following an allegation of abuse, for 2 of 2 residents (R162, R169) investigated for abuse. Findings include: R27's diagnoses report printed on 2/15/23, included dementia, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness or inability to move on one side of the body) following cardiovascular disease affecting his right dominant side. R27's quarterly Minimum Data Set (MDS) assessment dated 11/20/22, indicated R27 was	F 610	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: F610 It is the policy of Lyngblomsten that the facility responds to allegations of neglect, exploitation, or mistreatment by; conducting a thorough investigation, preventing any further potential abuse, neglect, exploitation or mistreatment while	

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F 610	Continued From page 13 cognitively intact, had adequate vision and hearing, clear speech, was understood and could understand. R27 required extensive assistance of one staff for most ADL's (activities of daily living) and did not walk. R27's care plan created on 8/12/22, indicated R27 had an alteration in ability to remove self from harm due to hemiplegia and hemiparesis of right side due to cerebral infarction (stroke). Progress notes in R27's electronic medical record (EMR) indicated: --2/10/2023, at 5:35 p.m., note entered by social services (SS)-A: Nursing assistant (NA)-C told writer that family member (FM)-C just told her R27's roommate, R162 - "threatened him" while she was visiting. FM-C had left. Writer spoke with R27. R27 stated R162 told him he would "kill him" and "punch him in the face". Writer asked R27 what precipitated this and R27 said they do not like each other because they both think the other one makes too much noise. Writer has offered ear plugs in the past and both have declined. R27 then stated R162 also threatened FM-C. Writer spoke with roommate R162 who stated he did say he would kill R27 but did not say he would punch him the face and only threatened R27. R162 stated he would not actually harm R27 and that he is "verbally aggressive but not physically aggressive." Writer asked R27 if he was scared or fearful to which he answered "no". Writer asked if he felt safe staying in the same room as his roommate this weekend and he stated he did. He stated that if R162 were to punch him, he would stomp on his foot in return. Nurse on shift and house supervisor notified. R27 is on private room waiting list. SS to continue to assist PRN	F 610	the investigations is in progress; and that all investigative results are reported to the Administrator or their designee, and other officials according to state law, including the State Survey Agency, within 5 working days of the incident, and take all appropriate corrective actions necessary. To assure continued compliance the following plan has been implemented: Regarding cited residents: With respect to resident R27, the incident referenced was reported by nursing administration when additional information was reported by the state surveyor on 2-13-23. Resident R27 was moved to a different room and neighborhood and assessed by the house psychologist for psychosocial harm and found to be not distressed and comfortable in his new room. Results of internal investigation substantiated allegation of resident to resident abuse as R27 endorsed feeling threatened to the state surveyor. With respect to R192, the resident was assessed for harm following her reports of rough treatment and verbal abuse by staff. Resident reported that the rough treatment and verbal abuse was witnessed by two staff members, interviews with both staff members does not support residents report. Resident has been observed and has not demonstrated any changes to her mood or behavior that indicates effects from the allegation. Resident care plan has been updated to reflect approaches and preferred caregivers to prevent future occurrences. Resident is scheduled to transfer to long term care section of the	

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F 610	Continued From page 14 (as needed). --2/10/2023, at 6:37 p.m., note entered by licensed practice nurse (LPN)-B: R27 reported to SS-A that roommate R162 threatened him this shift. R27 stated that they have had issues in the past about noise and the same continues. R27 told this writer, he spoke to SS-A about the ongoing noise issue and was aware he is on the waiting list for a room. Will continue to monitor the roommates per facility protocol. During an interview on 2/13/23, 2:48 p.m., R27 stated, "I have a terrible roommate, he keeps me up all night." R27 stated his roommate, R162, yelled and screamed due to his sore diabetic foot. R27 then stated R162 had threatened FM-C, saying "I'll get you too." From R27's room, FM-C was contacted via telephone. FM-C stated she had been at the facility the afternoon of 2/10/23, visiting R27. FM-C stated R162 had not been in the room when she arrived. When R162 did arrive to the room, he made loud sounds - described by FM-C as involuntary sounds that made her jump. When that happened, R27 said out loud that R162 did that all the time, which seemed to set off R162. With a urinal in hand, R162 walked to R27's side of the room where both FM-C and R27 were sitting and stated, "You SOB (son of a bitch) I could kill you." FM-C stated R162 had been so angry she thought he was going to throw urine at them. FM-C stated despite the raised voices, no staff came in to see what was going on. FM-C stated R162 called her and R27 names including boar head and stated, "I could just kill you." FM-C stated, "I felt sick to my stomach," adding it was so unexpected. FM-C stated she was very concerned about R27 and on	F 610	building. Actions taken to identify other potential residents having similar occurrences: Vulnerable adult investigating and protection requirements have been reviewed with all appropriate staff, with staff demonstrating compliance with their respective investigating and protection responsibilities. Facility administration has implemented a communication, documentation, and review process for all potential vulnerable adult abuse or neglect allegations to ensure those requiring reporting and investigations to the SA are done so appropriately and necessary protections are implemented. Measures put in place to ensure deficient practice does not occur: Facility reviewed the VA policy and facility guidance for reporting, investigations and protections, no revisions were made, however a secondary process was developed to communicate, document, and review all potential abuse and neglect allegations. Utilizing the facility online learning portal, education was developed that reviews the reporting, investigating and protection requirements for each staffs' respective responsibilities. Effective implementation of actions will be monitored by: Nursing Administration will review all allegations of abuse, neglect, exploitation or mistreatment for proper investigation and protection. Nursing Administration will conduct random knowledge audits of nursing staff, completing 3 audits per week for 1 month, then 1 audit per week for 2 months. Findings will be reported to	

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her way out of the facility at approximately 3:15 p.m. talked to a nursing assistant (NA), whose name she did not know. FM-C told the NA that R162 had been very upsetting and told her what R162 had said to her and R27. The NA replied, oh they do this. FM-C stated she told the NA that R162 was not joking; that he had been abusive to both her and R27, informing the NA it had been very upsetting. With telephone call to FM-C concluded, R27 stated one of the aids had witnessed this behavior in the past, but did not know her name. When asked how this incident made him feel, R27 stated he supposed R162 could hurt him if he snuck up on him, adding if he had to, he could hit R162 with his pick up stick, pointing to his orthopedic reacher-grabber. R27 stated he had to keep his mouth shut when around R162 so R162 didn't start yelling at him.

On 2/13/23, at 3:27 p.m., the DON stated he had been informed of the incident by registered nurse (RN)-E on 2/10/23, at 5:04 p.m. The DON admitted neither he nor anyone else had interviewed FM-C who had witnessed the incident since R162 had admitted to staff he had been verbally aggressive toward R27 and FM-C. The DON stated he did not feel it had been necessary to interview witness FM-C about the incident since R27 was cognitively intact and could describe what took place.

On 2/13/23, at 4:37 p.m., the DON informed surveyor that R27 would be relocated to a different room and FM-C had been contacted for an interview.

During an interview on 2/14/23, at 2:51 p.m., SS-A stated NA-C had talked to her after the incident on 2/10/22, in the "late afternoon." NA-C

F 610

Director of Nursing and Administrator.
Those responsible to maintain compliance will be:
The Director of Nursing and/or designee will audit the data collected which will be presented and discussed monthly at the Quality Assurance Committee meetings.
At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions.
Completion date for certification purposes only is 3-24-23

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told SS-A that R27 and R162 were not getting along; that R162 said something to R27 that upset him. SS-A stated she then talked to R27 and R162 separately in their room. Following the interviews, SS-A informed registered nurse (RN)-E who stated she would call FM-C. SS-A stated since R27 told her he felt safe, was not scared or fearful, was comfortable staying in his room, the two residents had not been separated.

During an interview on 2/14/23, at 3:00 p.m., NA-C stated FM-C had come to her on 2/10/23, complaining that R162 and R27 argued a lot and felt R162 had been bullying R27. FM-C told NA-C that R162 said he was going to kill R27. NA-C said she told FM-C that the two men joked around a lot, that R162 didn't mean it, and told FM-C she would let the supervisor know. NA-C stated she informed both licensed practical nurse (LPN)-B and SS-A what FM-C told her. When asked if she had heard the two men argue in the past, NA-C stated the two interacted a lot with each other, but she had not heard them argue...just joke around.

During a telephone interview on 2/15/23, at 10:49 a.m., LPN-B stated when informed of the incident on 2/10/23, she spoke to R27 and R162 who complained about the noises each other made. LPN-B stated she spoke to the residents separately and R27 told her what happened when FM-C was there -- that R162 threatened to kill them. LPN-B stated the residents had not been separated after the incident.

During an interview on 2/16/23, at 10:05 a.m., the DON acknowledged an investigation had not been conducted after the facility had been informed by FM-C of her concerns regarding

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threatening behavior by R162 towards R27. Witness FM-C had not been interviewed, R27 and R162 had not been separated, and employees with potential knowledge of the conduct between R27 and R162 had not been interviewed. In addition, other residents had not been assessed to determine if others had experienced verbal abuse by R162.

During an interview on 2/16/23, at 11:00 a.m., the administrator acknowledged that once the facility had been made aware of the incident on 2/10/23, an investigation should have been conducted as outlined in facility policy to ensure the safety of the residents.
R192

R192's significant change Minimum Data Set (MDS) assessment dated 1/7/23, identified R192 had diagnosis which included anemia (a deficiency of red blood cells) and atrial fibrillation (A-fib) (a heart condition where blood doesn't flow as well as it should). MDS indicated R192 had intact cognition and required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting.

R192's care plan revised 1/6/23, revealed R192 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 to remove R192 from any potential harmful situations.

During an interview on 2/14/23, at 5:02 p.m. R192 stated a few weeks ago during cares nursing assistant (NA)-A became angry and cursed when he had to change R192's incontinent product.

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LYNGBLOMSTEN CARE CENTER	1415 ALMOND AVENUE SAINT PAUL, MN 55108

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F 610	Continued From page 18 R192 stated when NA-A turned her he was rough and she was scared. R192 stated she had reported her concerns to the director of nursing (DON) a few days later. R192 further stated DON had informed her NA-A would no longer work with her. Review of facility reported incidents to the SA lacked documentation of an investigation report being submitted to the SA. During an interview on 2/15/23, at 8:17 a.m. NA-A confirmed he continued to work with other residents after the allegation of abuse had occurred. During an interview on 2/15/23, at 8:45 a.m. registered nurse (RN-A) confirmed NA-A was allowed to continue working with other residents after the allegation of abuse had occurred. During an interview on 2/15/23, at 2:30 p.m. RN-B at confirmed NA-A was allowed to continue working with other residents after the allegation of abuse had occurred. During an interview on 2/15/23, at 3:03 p.m. RN-C confirmed NA-A was allowed to continue working with other residents after the allegation of abuse had occurred. During an interview on 2/15/23, at 3:08 p.m. licensed practical nurse (LPN)-A stated on 2/4/23, R192 said she was scared because NA-A was still working on her unit. During an interview on 2/15/23, at 11:30 a.m. DON confirmed NA-A had been allowed to work with other residents after the allegation of abuse	F 610		

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F 610	Continued From page 19	F 610		

had occurred. DON stated if he had suspected rough care NA-A would have been removed from the schedule during the investigation.

Facility policy titled Vulnerable Adult / Abuse Prevention with revised date of 3/2022, indicated a vulnerable adult investigation would be completed for all suspected abuse/neglect concerns and turned into the administrator, DON, or designee. While investigating the incident, interview the involved resident, family member(s) if appropriate, neighborhood interdisciplinary staff as appropriate, and any others who may have information to share. Document statements or have them provide a written statement. Conduct observations of interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents. Conduct interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses. Conduct a record review for pertinent information related to the alleged violation, as appropriate, such as progress notes.

Facility policy titled Resident to Resident Altercation with revised date of 10/2019, indicated if a resident to resident altercation was suspected or alleged, the facility would take the following actions: Remove the aggressor(s) from the area, and ensure the safety of the residents, staff and /or visitors in the area. Ensure the individual(s) are protected from other potential altercations at the time of the incident. Interview witnesses to determine the presenting behaviors and antecedents to the incident. Document the situation on an Incident/Accident Report for each of the parties involved, including a physical assessment for both of the parties involved.

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		3/24/23

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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 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.

F 656

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:

F656
It is the policy of Lyngblomsten that the facility develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights and includes measurable 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 of his catheter and had catheter removed

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When interviewed on 2/14/23, at 7:45 a.m. R199 stated he has had a Foley catheter in since he was admitted to the facility on 12/26/22.

During an interview on 2/15/23, at 8:41 a.m. nursing assistant (NA)-B stated that he follows the care plan to care for R199's indwelling Foley catheter. NA-B confirmed the care plan lacked interventions to care for R199's indwelling Foley catheter.

During an interview on 2/15/23, at 8:45 a.m. registered nurse (RN)-D confirmed R199's indwelling Foley catheter is not listed in R199's care plan and stated that it was important that an indwelling Foley catheter be listed in the comprehensive care plan so that all staff are aware that R199 has an indwelling catheter and know how to care for the indwelling Foley catheter. RN-D stated her expectation would have been that R199's indwelling Foley catheter would have been in R199's comprehensive care plan.

During an interview on 2/15/23, at 11:30 a.m. director of nursing (DON) confirmed R199's indwelling Foley catheter was not in R199's comprehensive care plan. DON stated his expectation would have been that R199 ' s indwelling foley catheter would have been included in R199's comprehensive care plan.

Facility policy titled Comprehensive Care Plans, dated 5/22, identified each resident would have a person-centered comprehensive care plan developed and implemented to meet their preferences and goals, and address their medical, physical, mental and psychosocial

F 656

prior to discharge.
Actions taken to identify other potential residents having similar occurrences:
All other residents with catheters were reviewed for proper care plan problems, goals and interventions related to their indwelling catheters, all were appropriately care planned, no additions or revisions were needed.
Measures put in place to ensure deficient practice does not occur:
The nurse responsible to appropriately care plan the catheter for R199 was re-educated on the care plan requirements for a resident with a catheter. All other nurses that develop, review, or revise care plans have been educated on the expectations and requirements for catheter care plans and what to do if a catheter care plan is not appropriately in place.
Effective implementation of actions will be monitored by:
Nursing administration will routinely identify and review all residents with catheters and audit record for all regulatory and facility required elements for the effective care and management of an indwelling urinary catheter.
Those responsible to maintain compliance will be:
The Director of Nursing and/or designee will audit catheter listing report weekly for four weeks for the required elements, including care plan problem, goals and interventions. Then audit monthly for 3 months to assure ongoing compliance.
The data collected will be presented and discussed monthly at the Quality

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F 656	Continued From page 23 needs. The policy identified a CAA is used to determine of the care area triggers require interventions and care planning. The policy further identified the comprehensive care plan would have been completed within 7 days of the completion of the comprehensive assessment.	F 656	Assurance Committee meetings by the Director of Nursing. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions. Completion date for certification purposes only is 3-24-23.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		3/24/23

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§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to provide routine catheter hygiene care for 1 of 2 residents (R138), reviewed for catheter care; who had an indwelling catheter, was at risk for infection, and had a history of urinary tract infections (UTIs).

Findings include:

R138's face sheet, printed on 2/16/23, indicated R138 was admitted to facility on 10/31/22.

R138's diagnosis report, printed on 2/16/23, consisted of infection and inflammatory reaction due to indwelling urethral catheter, urinary tract infection, mild cognitive impairment, benign prostatic hyperplasia ((BPH)-prostate enlargement), retention of urine, and chronic kidney disease (CKD).

R138's significant change minimum data set (MDS) assessment, dated 12/21/22, identified R138 having intact cognition, required assist of 1 staff for toileting and personal hygiene, had an indwelling catheter and a diagnosis of urinary retention.

R138's physician order summary report, printed on 2/16/23, indicated foley catheter change every month every evening shift starting on the 3rd and

F 690

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:

F690
It is the policy of Lyngblomsten that the facility ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident’s clinical condition demonstrates that catheterizations is necessary. A resident who is incontinent of bladder receives appropriate treatment and services to

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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 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

prevent urinary tract infections and to restore continence to the extent possible.
To assure continued compliance the following plan has been implemented:
Regarding cited residents:
With respect to resident R138, his care plan, including care sheets, were reviewed and updates made to indicate frequency of peri-care. Record review shows the resident has not experienced any complications from the lack of peri-care noted on 2-16-23.
Actions taken to identify other potential residents having similar occurrences:
All other residents.
Measures put in place to ensure deficient practice does not occur:
All other residents with catheters were reviewed for proper care plans, including review of care sheets and frequency of peri-care. all were appropriately care planned, no additions or revisions were needed.
Effective implementation of actions will be monitored by:
All nursing staff that provide care for residents who have indwelling urinary catheters have been re-educated on proper peri-care for residents with catheters, including the expectation that peri-care is completed routinely when providing daily cares, unless otherwise specified. All nurses that develop, review, or revise care plans have been educated on the expectations and requirements for catheter care plans and the completion of peri-care. Policy for perineal care was developed and implemented.
Those responsible to maintain compliance

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R138, urine culture was negative at time.

Review of nursing assistant (NA) care sheet, printed on 2/16/23, indicated staff assist of 1-2 for R138's toileting cares, staff to provide R138 with foley catheter cares every shift, staff to empty R138's catheter bags every shift-document/update nurse with outputs, staff to remember to rinse R138's catheter bags with vinegar per protocol.

Review of NA-E's, 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 (empty/change/store/clean), observes resident skin daily with cares and documents findings, and follows care planned individualized toileting plan.

During an observation and interview, on 2/16/23 at 7:35 a.m., NA-E noted to use hand sanitizer prior to entering R138's room to perform catheter care. NA-E placed a pair of clean gloves on hands, took night bag out of covering holder located behind R138's wheelchair, removed, night bag tubing from plastic holder, cleansed end tip of night bag with alcohol wipe, released lock on bag and emptied into graduated cylinder, locked night bag tubing, alcohol wiped end tip of night bag, placed back into plastic holder of night bag, placed night bag back into covering holder behind wheelchair, took graduated cylinder with urine into R138's bathroom, emptied urine into toilet, rinsed cylinder with water from sink, emptied water from graduated cylinder into toilet, flushed toilet, placed graduated cylinder on ledge behind

Provider's Plan of Correction (F 690):

will be:
The Director of Nursing and/or designee will audit catheter listing report weekly for four weeks for the required elements, including care plan interventions, specifically peri-care frequency. Then audit monthly for 3 months to assure ongoing compliance. The data collected will be presented and discussed monthly at the Quality Assurance Committee meetings by the Director of Nursing. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions.
Completion date for certification purposes only is 3-24-23.

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F 690	Continued From page 27 toilet, removed gloves and placed into garbage can, washed hands with soap/water at bathroom sink, grabbed paper towels to dry hands and threw paper towel into garbage can. NA-E was asked if she had completed peri-care/foley catheter earlier that morning, as peri-care/foley catheter care not completed at time of observation, NA-E responded peri-care/foley catheter care had not been completed during routine morning cares. NA-E was asked when peri-care/foley catheter care was typically provided, NA-E responded peri-care was provided for R138 after R138 had a bowel movement (BM) earlier that morning, cleansing rectal area only. NA-E stated routine peri care/foley catheter care was completed on R138's shower days and per R138's request, NA-E indicated routine peri care/foley catheter care was not completed on a daily basis. NA-E stated when determining residents' care needs, she reviewed the daily NA care sheet, and indicated R138's care sheet did not list for peri-care/foley catheter care to be provided, only listed switching of urinary bags, cleansing used urinary bag with vinegar solution, emptying urinary bag during shift as needed and recording urinary output. During conversation with NA-E, R138 reported staff do not routinely provide peri care/catheter care, stated he had a UTI while in the facility, denied having any urinary symptoms at time when asked. While interviewed, on 2/16/23 at 8:58 a.m., NA-F indicated awareness of R138's catheter care needs, had not provided routine peri care/foley catheter care in past for R138, stated licensed nursing completed due to risk for infections with indwelling catheter.	F 690		

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F 690	Continued From page 28 During an interview, on 2/16/23 at 9:02 a.m., licensed practical nurse (LPN)-C indicated all NA's were trained to complete routine peri-cares, including cares for indwelling catheters. LPN-C stated NA's are expected to complete routine peri care/catheter cares twice daily, in morning and at night for all residents, licensed nursing follows up with NA's towards end of shift to ensure task completed. LPN-C indicated R138's peri care/catheter cares should be completed by NAs, no special circumstances for only licensed nurse to complete per LPN-C knowledge. While interviewed, on 2/16/23 at 10:52 a.m., the director of nursing (DON) indicated all NA's receive training to provide routine peri care/catheter care upon hire, yearly, and as needed (PRN), NA's complete a checklist signed off by licensed nursing. The DON stated all NA's were able and expected to provide routine peri care/catheter care for all residents during morning and bedtime cares, as well as whenever needed. The DON indicated NA care sheets did not need to indicate NA's are to complete routine peri care/catheter care for each resident, as providing routine peri care/catheter care was a normal standard of care known to all nursing staff. Facility policy titled Catheter Care- Urinary Drainage and Leg Bag, revised date 6/22, was received, did not indicate provision of peri care with indwelling catheter in policy/procedure.	F 690		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		3/24/23

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§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
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.

Findings include:

During interview and observation of kitchen on 2/13/22 at 2:10 p.m., with certified dietary manager (CDM)-A, observed food items in the walk-in produce refrigerator and dry goods room

The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:

F812
It is the policy of Lyngblomsten that the facility store, prepare, distribute, and serve food in accordance with professional standards for food service safety. To assure continued compliance the following plan has been implemented:

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F 812	Continued From page 30 that were not dated or marked and/or were expired. CDM-A indicated food production manager (FPM)-B typically went through all food 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 were stacked one on top of the other, top plastic food storage container lid had several white, dried	F 812	Regarding cited residents: Food items noted during survey to appear spoiled were discarded. All food storage areas have been inspected and all outdated or spoiled food items were discarded. Actions taken to identify other potential residents having similar occurrences: All residents can potentially be affected by deficient practice related to food service. Measures put in place to ensure deficient practice does not occur: All food will be dated at the time of delivery, by facility staff or by vendors. Dates will be placed on the bulk packaging e.g. cases, flats, etc. Facility will use "best by" dates as a rough guide, not expiration dates per industry standards, allowing for additional days if food items appear fresh and palatable. Produce is often not labeled with "use by" or "best by" dates so staff will evaluate each item for signs of rot or deterioration at time of use and discard if appears to be spoiled. Kitchen staff were re-educated on the signs of rot and deterioration. "Date opened" stickers will be filled out and placed on opened items prior to storage. Open produce will be discarded after 7 days regardless of odor/appearance; however, it may be discarded prior to 7 days if signs of rot or deterioration are noted. Monitoring will be done will be done by the Food Production Manager when orders are being prepared, at least twice weekly. Staff will be re-educated as necessary when knowledge deficits are identified. Policies have been reviewed and revised to clarify	

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F 812	Continued From page 31 areas, which resembled water spots. During an observation with CDM-A, on 2/15/23 at 10:35 a.m., DA-A removed pan of skewered shrimp from oven, set pan on food prep table, grabbed thermometer from kitchen drawer, removed plastic cap from tip of thermometer, inserted tip of thermometer into skewered shrimp to temp shrimp, removed thermometer from shrimp, alcohol wiped tip of thermometer, set thermometer down on food prep table. When interviewed, on 2/13/23 at 2:10 p.m., CDM-A indicated when food and beverage items were delivered to facility, staff would rotate food items, place older food items towards the front, newer food items towards the back, older food items to be used up first. CDM-A stated when food items were opened, staff were to mark date when opened so staff would be aware of when to discard items if beyond facility policy expiration date. CDM-A indicated staff should be checking fresh produce daily, if food appeared dry, discolored, had increased moisture, or was foul smelling, food should be discarded immediately. During an interview, on 2/15/23 at 10:41 a.m., DA-A indicated would typically cleanse tip of thermometer with alcohol wipe prior to and after insertion of food when temping food. When interviewed, on 2/15/23 at 10:47 a.m., CDM-A indicated all staff temping food should be cleansing tip of thermometer with alcohol wipe prior to and after insertion into food. Facility policy titled Food Storage, reviewed date 11/22, consisted of; leftover food will be stored in covered containers or wrapped carefully and	F 812	how items will be labeled and how long they may be kept. Leftover/prepared food will be used or discarded within 3 days (this does not apply to unopened produce). Staff were re-educated on proper handling/stacking of items on the drying rack, items will be removed and stored in the appropriate storage areas only when completely dry. Care will be taken to not place wet items above dry items as able, if a wet item drips onto a dry item both items will remain on the drying rack until dry. Staff responsible for taking food temperatures were each issued their own thermometers and re-educated regarding how to properly take a temperature and when and how to sanitize the thermometer. Effective implementation of actions will be monitored by: The Director of Culinary and Nutritional Services and/or designee will audit food storage areas for proper labeling, dating, and odor/appearance weekly for one month, then biweekly for two months. Those responsible to maintain compliance will be: Director of Culinary and Nutritional Services will review their respective audit information, concerns noted and corrective actions taken, compiling the information before presenting to the monthly Quality Assurance Committee meetings for discussion. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies or actions. Completion date for certification purposes	

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F 812	Continued From page 32 securely, each item will be clearly labeled and dated before being refrigerated, leftover food is used within 7 days or discarded per the 2017 Federal Food Code; all foods will be checked to assure that foods (including leftovers) will be consumed by their safe use dates, or frozen, or discarded. Facility policy titled Covering, Labeling, and Dating of Food, reviewed date 11/22, consisted of; food items stored in the walk-in refrigerator and freezer will be covered, labeled, and dated by the cooks and dietary aides to ensure safety and proper rotation, all food items shall be discarded within 48-72 hours of labeled date, the Food Production Manager will inspect the walk-ins and freezer for uncovered, unlabeled or dates past due when major ordering is done 2x/week, cooks and dietary aides are also responsible to discard items as they see them or bring it to attention of the Food Production Manager. FDA Food Code 2022, clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. 4-901.11 Equipment and Utensils, Air-Drying Required. Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. 4-602.11 Equipment Food-Contact Surfaces and Utensils. Equipment food-contact surfaces and utensils shall be cleaned: before each use with a different type of raw animal FOOD such as beef, FISH, lamb, pork, or POULTRY; Each time there is a change from working with raw FOODS to working with READY-TO-EAT FOODS; Between uses	F 812	only is 3-24-23.	

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F 812	Continued From page 33 with raw fruits and vegetables and with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD; Before using or storing a FOOD TEMPERATURE MEASURING DEVICE; At any time during the operation when contamination may have occurred.	F 812		
F 880 SS=F	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 communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		3/24/23

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F 880	Continued From page 34 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and	F 880	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	

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Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19, when during a Covid-19 outbreak and high Covid-19 community transmission, residents, visitors and staff were observed not wearing appropriate personal protective equipment (PPE), specifically masks. This had the potential to affect all 211 residents who resided in the facility.

Findings include:

The facility was in outbreak status when R307, who was admitted on 2/3/23, tested positive for Covid-19 on 2/7/23, and was in transmission based precautions. In addition, the county community transmission level for Covid-19 was high.

During an observation on 2/13/23, at 3:30 p.m., observed two signs at the main entrance of the facility regarding visitor masking. Neither signs were on the door as individuals entered the facility. Both signs were laying flat, one on a credenza inside the main entrance and one on the receptionists desk. A visitor would need to stop and look for the signs in order to see/read them. The two signs dated 11/29/22, read: ATTENTION VISITORS AND GUESTS: Visitors to the Care Center are no longer required to complete a Covid-19 entrance questionnaire or temperature check when entering the building. However, we ask that you refrain from visiting if you are experiencing or have experienced any of the following: tested positive for Covid in the last 10 days, have Covid-like symptoms, have had close contact with a Covid-positive individual in the last 10 days. Currently visitors are asked to wear face coverings or masks when visiting residents as the Covid transmission level is HIGH

F 880

as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiency. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that:

F880
It is the policy of Lyngblomsten Care Center that the facility establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. To assure continued compliance the following plan has been implemented.
Regarding cited residents:
With respect to residents referenced in the summary statement: R130, R148, R163, R255, R101, R85, R126, R65, R32, R49, R131, R26, R129, R119, R56, R120, R97, R53 have all been individually informed of the current requirement to mask when outside their rooms and not eating. Signage informing individuals of the current masking requirements within the building have been relocated to areas and perspectives that afford greater visibility and readability. Signage has been revised to indicate the current community transmission level, building outbreak status and the appropriate masking requirement.
Actions taken to identify other potential

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in the surrounding community.

During an observation on 2/13/23, at 3:45 p.m., a sign was noticed on a wall entering the TCU (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 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)

F 880

residents having similar occurrences:
All residents have an increased risk of infection when recommended masking requirements are not followed.
Measures put in place to ensure deficient practice does not occur:
Root Cause Analysis completed for the facilities failure to properly follow the CMS source control masking requirements.
Causal factors revealed information deficits among residents and some visitors related to a failure to clearly communicate masking requirements and to correct identified ongoing deficits. Also identified were conflicting messaging on masking requirements by the facility and poor visibility of that messaging. Steps implemented to re-educate residents and visitors using effective messaging through a variety of methods, including but not limited to: individual communications, enhanced signage, written communications, and verbal reminders.
Key personnel at entrance locations have been instructed to monitor for masking compliance among visitors and others and how to effectively inform the individuals of the current masking requirements. Mask dispensing stations have been placed at key entrances- visitor and employee- along with signage to remind individuals of the masking requirements and provide easily accessible masks. Additionally, mask dispensers have been purchased and will be placed in key locations throughout the building for ease of access to staff, residents and visitors. Staff will routinely provide masks for residents.
Three new policies have been created to

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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 (TC)-A stated resident masking had not been recommended for awhile, adding she did not encourage residents to wear a mask as she had not heard masking was required for residents...it was just mandatory for staff.

-- On 2/15/23, at 11:47 (TC)-B stated she thought masking was a choice for the residents rather than mandatory and that it depended on the resident, as some did not understand why a mask was needed. TC-B stated she sometimes asked residents if they wanted a mask, but did not do it consistently. TC-B stated she had not heard the facility was in Covid-19 outbreak status.

--On 2/15/23, at 1:32 p.m., R101 was who was in a wheelchair, self propelling in her third floor hallway near the dining room stated, "We don't need to wear a mask anymore." When asked if staff encouraged her to wear a mask when outside of her room, R101 replied, no, "They don't tell us to unless we're going to the doctor." According to quarterly Minimum Data Set (MDS) assessment dated 11/9/22, R101 was cognitively intact.

-- On 2/15/23, at 1:52 p.m., R56 was resting in her recliner watching TV. R56 was asked if she knew if residents needed to wear masks when out of their room and replied no one had told her that, or had staff asked her to wear a mask outside of her room. According to admission MDS assessment dated 1/15/23, R56 was cognitively intact.

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address, masking, gown wearing and PPE use during conventional, contingency, and crisis capacities: Masking as Source Control, Gown Use for Transmission Based Precautions, and Optimizing PPE. Facility Infection Control policy was reviewed and remains consistent with current requirements and recommendations, no changes were made. Facility COVID-19 Infection Control policy was reviewed during the survey and revised at that time. All staff have been re-educated on the purpose and requirements of source control masking. All Nursing staff have been re-educated on the proper use of, including the donning and doffing, all PPE. Staff will be required to demonstrate competency in the proper use of PPE. Residents and their representatives will be educated on the purpose of source control masking, it benefits, how masking requirements are determined and how that information will be communicated to them.
Effective implementation of actions will be monitored by:
The Infection Preventionist and/or designee will audit PPE- both the proper donning and doffing of PPE by staff and the appropriate use of source control masking for all staff, residents and visitors. Donning and doffing audits will occur weekly, as able, determined by in place transmission-based precautions. Audits of source control masking will be completed for all shifts four time a week for one week and that twice weekly for one week after 100% compliance is met.

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-- On 2/15/23, at 3:40 p.m., R120 was walking in a resident hallway with her walker on second floor, on her way to play cards. R120 stated she didn't think she had to wear a mask anymore and, "Staff haven't reminded me." According to quarterly MDS assessment dated 12/28/22, R120 was cognitively intact.

-- On 2/15/23, at 3:53 p.m., R97 who was seen earlier on first floor in electric wheelchair with a mask on, and who was now in his room on his laptop stated, "I wear a mask if I'm on first floor, but not in the hallways up here. I haven't been told I need to." According to quarterly MDS assessment dated 12/14/22, R97 was cognitively intact.

-- On 2/15/23, at 3:57 p.m., R53 was in a resident hallway on third floor in his electric wheelchair, side by side with R87 who was also in a wheelchair. R53 was not wearing a mask and R87's mask was below his chin. R53 stated, "I don't think we have to wear masks, staff doesn't tell me to." According to quarterly MDS assessment dated 12/14/22, R53 was cognitively intact.

-- On 2/16/23, at 8:50 a.m., nursing assistant (NA)-D on third floor stated it was no longer required for residents to mask when out of their room; masks were only required for staff.

Observations and interviews of VISITOR masking:
-- On 2/14/23, at 3:48 p.m., family member (FM)-F was on fourth floor without a mask, on her way to the coffee shop on first floor. FM-F stated she didn't think visitors needed to wear a

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Infection Preventionist will monitor infection trends and report any suspected to be linked to improper PPE use, including source control masking.
Those responsible to maintain compliance will be:
The Root Cause Analysis was reviewed with the Quality Assurance Committee and the Governing Body President. Any ongoing audit data collected will be presented to the Quality Assurance committee by the Infection Preventionist monthly. The data will be reviewed/discussed at the monthly Quality Assurance Meeting. At that time the Quality Assurance committee will make the decision/recommendation regarding any necessary follow-up studies.
Completion date for certification purposes only is: 3-24-23.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880		F 880		

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mask..."No one has told me I need to." FM-F stated if she should wear a mask, she would.

-- On 2/15/23, at 2:40 p.m., (FM)-G who was unmasked was observed in the hallway on fourth floor on his way to see R52. FM-G stated he never wore a mask; no one had told him he needed to but was not opposed to wearing a mask. FM-G visited R52 daily.

-- On 2/16/23, at 8:52 a.m., (FM)-H who was unmasked, was in the hallway on third floor at the nurses station talking to nursing assistant (NA)-D. FM-H stated he had not worn a mask in the facility for quite awhile...adding no one had told him he should. FM-H stated he wore a mask about 50% of the time when he came to to visit.

-- On 2/16/23, 9:03 a.m., main entrance receptionist (R)-I, when asked what her role was in visitor masking, stated she encouraged visitors to wear a mask if they asked, but understood visitor masking to be optional.

During an interview on 2/16/23, at 9:44 a.m., the DON stated the ADON-E had talked to him about visitor and resident masking. The DON stated they would do a little more to ask people to wear masks, adding they encouraged visitors and residents, but couldn't force them to wear masks. The DON was informed of observations and interviews of residents and visitors without masks.

During an interview on 2/16/23, at 10:43 a.m., the ADON-E was informed of observations and interviews of residents and visitors without masks. The ADON-E stated the way she interpreted the CDC and CMS guidelines,

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masking was not mandatory, even during Covid-19 outbreak status and during high community transmission. The ADON-E stated Covid-19 had been going on a long time and residents didn't want to wear masks anymore, adding many stopped taking Covid-19 boosters and they could see residents were sick and tired of it [Covid-19]. The ADON-E stated she had not re-educated residents on wearing masks and didn't know if anyone else had. The ADON-E admitted in her role, she would likely be the one to bring up re-education to the leadership team. The ADON-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 ADON-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., (ADON)-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 were not available at the back entrance. TMA-A 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

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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 staff were required a mask prior to entering a resident care area, and confirmed masks were unavailable to staff at the back employee entrance.

Facility policy titled Covid-19 Infection Control Guidelines, with revised date of 2/13/2023, indicated the purpose was to provide guidance on the prevention of Covid-19 and to prevent and minimize exposures to respiratory pathogens. The Care Center would regularly monitor the CDC and CMS website's for the most up to date information and resources, and would adhere to guidance for visitation detailed within revised CMS Memorandum QSO 20-39 dated 9/23/22. The facility would utilize core principles of face covering or masking when permitting visitation to reduce the risk of Covid-19 and visitors would be given source control facemasks. PPE was used to protect staff and residents from the transmission of potentially dangerous and/or infectious pathogens. Face masks would be worn by all staff at all times when in resident care areas. Staff could momentarily lower their mask to access their mouths as needed (e.g. to take a drink). Staff should only lower their mask when a safe distance for others (e.g. 6 feet).

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LYNGBLOMSTEN CARE CENTER	**1415 ALMOND AVENUE** **SAINT PAUL, MN 55108**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/14/2023. At the time of this survey, Lyngblomsten Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		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.

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

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

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Lyngblomsten Care Center is a 4-story building with a full basement. The building was constructed at two different times. The original building was constructed in 1962 and was determined to be of Type II(222) construction. In 1976, an addition was constructed to the Southside that was determined to be of Type II(222) construction. Because the original building and the one addition are of the same type of construction, the facility was surveyed as one building.

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K 000	Continued From page 2 The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 225 beds and had a census of 216 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect Fire doors per NFPA 101 (2012 edition), Life Safety Code, sections, 19.7.6, 8.3.3.1, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1.	K 761	K761 To meet the requirements of maintenance, inspection and testing doors, fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for	4/3/23

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K 761	Continued From page 3 This deficient finding could have a widespread impact on the resident within tehfacility. Findings include: On 02/14/2023 at 0920 AM, it was revealed by observation or a review of available documentation that the facility did not conduct annual fire door inspections. An interview with Facility Director of Maintenance verified this deficient finding at the time of discovery.	K 761	Fire Doors and Other Opening Protectives. Physical Plant staff will test, inspect fire doors and document same. Physical Plant Director will audit for compliance. Date completed by 04-03-2023	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement an all hazards risk assesment per NFPA 99 (2012 edition), Health Care Facilities Code, Chapter 4. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 901	K901 To meet requirements of implementing a hazard risk assessment per NFPA 99 (2012 edition), Health Care Facilities Code, Chapter 4, the facility safety committee implemented an all hazards risk assessment. Physical Plant Supervisor will assure review for compliance annually.	4/3/23

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K 901	Continued From page 4 On 02/14/2023 at 0920 AM, it was revealed by a review of available documentation that the facility did not have a current copy of their Health risk assessment for review. An interview with the Director of Maintenance verified this deficient finding at the time of discovery	K 901	Date completed by 04-03-2023	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct Electrical Systems - Maintenance and Testing per	K 914	K914 To meet requirements of all resident room electrical receptacles being tested on an	4/17/23

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K 914	Continued From page 5 NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/14/2023 at 0930 AM, it was revealed by a review of available documentation that the Facility has not did their annual outlet testing for resident rooms. An interview with Director of Maintenance verified this deficient finding at the time of discovery.	K 914	annual basis per NFPA 99, sections 6.3.3.2 through 6.3.3.2.4 and6.3.4.1.3, Physical Plant staff will initiate and complete annual testing and documentation of all non-hospital grade resident room electrical receptacles. Physical Plant Supervisor will audit for compliance on a periodic basis. Date completed by 04-17-2023	
K 916 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Essential Electric System Alarm Annunciator NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.17. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 916	K916 To meet requirements of maintaining a essential electric system alarm annunciator NFPA 99 (2012 edition) the facility must have the emergency stop button for the generator readily seen and available. Physical Plant Supervisor will monitor for continued compliance on a	4/3/23

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K 916	Continued From page 6 On 02/14/2023 at 10:30 AM, it was revealed by observation the emergency stop button for the generator was located behind a shelving unit on the 1st floor nursing station. An interview with Director of Maintenance verified this deficient finding at the time of discovery.	K 916	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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00501	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 02/16/2023

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 2/13/23-2/16/23, a licensing survey and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you

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	00501	A. BUILDING: ____ B. WING ____	C 02/16/2023

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2 000	Continued From page 1	2 000		

have reviewed these orders and identify the date when they will be completed.

The following complaints were reviewed with no deficiency issued, H53478496C(MN00090965), H53478214C(MN00090860), H53478209C(MN00083852), H53478208C(MN00085747), H53478207C(MN00087959), and H53478206C(MN00090679).
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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. 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.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN 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.	2 565	Corrected	3/24/23

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2 565	Continued From page 3 R199's admission Minimum Data Set (MDS) assessment dated 1/10/23, indicated R199 was 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. When interviewed on 2/14/23, at 7:45 a.m. R199 stated he has had a Foley catheter in since he was admitted to the facility on 12/26/22. During an interview on 2/15/23, at 8:41 a.m. nursing assistant (NA)-B stated that he follows the care plan to care for R199's indwelling Foley catheter. NA-B confirmed the care plan lacked interventions to care for R199's indwelling Foley catheter. During an interview on 2/15/23, at 8:45 a.m. registered nurse (RN)-D confirmed R199's indwelling Foley catheter is not listed in R199's care plan and stated that it was important that an indwelling Foley catheter be listed in the comprehensive care plan so that all staff are aware that R199 has an indwelling catheter and know how to care for the indwelling Foley catheter. RN-D stated her expectation would have been that R199's indwelling Foley catheter would have been in R199's comprehensive care plan. During an interview on 2/15/23, at 11:30 a.m.	2 565		

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2 565	Continued From page 4 director of nursing (DON) confirmed R199's indwelling Foley catheter was not in R199's comprehensive care plan. DON stated his expectation would have been that R199 ' s indwelling foley catheter would have been included in R199's comprehensive care plan. Facility policy titled Comprehensive Care Plans, dated 5/22, identified each resident would have a person-centered comprehensive care plan developed and implemented to meet their preferences and goals, and address their medical, physical, mental and psychosocial needs. The policy identified a CAA is used to determine of the care area triggers require interventions and care planning. The policy further identified the comprehensive care plan would have been completed within 7 days of the completion of the comprehensive assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 835	MN Rule 4658.0520 Subp. 2 A Adequate and Proper Nursing Care; Criteria Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 835		3/15/23

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2 835	Continued From page 5 Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine catheter hygiene care for 1 of 2 residents (R138), reviewed for catheter care; who had an indwelling catheter, was at risk for infection, and had a history of urinary tract infections (UTIs). Findings include: R138's face sheet, printed on 2/16/23, indicated R138 was admitted to facility on 10/31/22. R138's diagnosis report, printed on 2/16/23, consisted of infection and inflammatory reaction due to indwelling urethral catheter, urinary tract infection, mild cognitive impairment, benign prostatic hyperplasia ((BPH)-prostate enlargement), retention of urine, and chronic kidney disease (CKD). R138's significant change minimum data set (MDS) assessment, dated 12/21/22, identified R138 having intact cognition, required assist of 1 staff for toileting and personal hygiene, had an indwelling catheter and a diagnosis of urinary retention. R138's physician order summary report, printed on 2/16/23, indicated foley catheter change every month every evening shift starting on the 3rd and 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	2 835	Corrected	

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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 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 R138, urine culture was negative at time.

Review of nursing assistant (NA) care sheet, printed on 2/16/23, indicated staff assist of 1-2 for

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R138's toileting cares, staff to provide R138 with foley catheter cares every shift, staff to empty R138's catheter bags every shift-document/update nurse with outputs, staff to remember to rinse R138's catheter bags with vinegar per protocol.

Review of NA-E's, 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 (empty/change/store/clean), observes resident skin daily with cares and documents findings, and follows care planned individualized toileting plan.

During an observation and interview, on 2/16/23 at 7:35 a.m., NA-E noted to use hand sanitizer prior to entering R138's room to perform catheter care. NA-E placed a pair of clean gloves on hands, took night bag out of covering holder located behind R138's wheelchair, removed, night bag tubing from plastic holder, cleansed end tip of night bag with alcohol wipe, released lock on bag and emptied into graduated cylinder, locked night bag tubing, alcohol wiped end tip of night bag, placed back into plastic holder of night bag, placed night bag back into covering holder behind wheelchair, took graduated cylinder with urine into R138's bathroom, emptied urine into toilet, rinsed cylinder with water from sink, emptied water from graduated cylinder into toilet, flushed toilet, placed graduated cylinder on ledge behind toilet, removed gloves and placed into garbage can, washed hands with soap/water at bathroom sink, grabbed paper towels to dry hands and threw paper towel into garbage can. NA-E was asked if she had completed peri-care/foley

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catheter earlier that morning, as peri-care/foley catheter care not completed at time of observation, NA-E responded peri-care/foley catheter care had not been completed during routine morning cares. NA-E was asked when peri-care/foley catheter care was typically provided, NA-E responded peri-care was provided for R138 after R138 had a bowel movement (BM) earlier that morning, cleansing rectal area only. NA-E stated routine peri care/foley catheter care was completed on R138's shower days and per R138's request, NA-E indicated routine peri care/foley catheter care was not completed on a daily basis. NA-E stated when determining residents' care needs, she reviewed the daily NA care sheet, and indicated R138's care sheet did not list for peri-care/foley catheter care to be provided, only listed switching of urinary bags, cleansing used urinary bag with vinegar solution, emptying urinary bag during shift as needed and recording urinary output. During conversation with NA-E, R138 reported staff do not routinely provide peri care/catheter care, stated he had a UTI while in the facility, denied having any urinary symptoms at time when asked.

While interviewed, on 2/16/23 at 8:58 a.m., NA-F indicated awareness of R138's catheter care needs, had not provided routine peri care/foley catheter care in past for R138, stated licensed nursing completed due to risk for infections with indwelling catheter.

During an interview, on 2/16/23 at 9:02 a.m., licensed practical nurse (LPN)-C indicated all NA's were trained to complete routine peri-cares, including cares for indwelling catheters. LPN-C stated NA's are expected to complete routine peri care/catheter cares twice daily, in morning and at

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night for all residents, licensed nursing follows up with NA's towards end of shift to ensure task completed. LPN-C indicated R138's peri care/catheter cares should be completed by NAs, no special circumstances for only licensed nurse to complete per LPN-C knowledge.

While interviewed, on 2/16/23 at 10:52 a.m., the director of nursing (DON) indicated all NA's receive training to provide routine peri care/catheter care upon hire, yearly, and as needed (PRN), NA's complete a checklist signed off by licensed nursing. The DON stated all NA's were able and expected to provide routine peri care/catheter care for all residents during morning and bedtime cares, as well as whenever needed. The DON indicated NA care sheets did not need to indicate NA's are to complete routine peri care/catheter care for each resident, as providing routine peri care/catheter care was a normal standard of care known to all nursing staff.

Facility policy titled Catheter Care- Urinary Drainage and Leg Bag, revised date 6/22, was received, did not indicate provision of peri care with indwelling catheter in policy/procedure.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all physician orders for residents with catheters to ensure cares are performed as ordered. The director of nursing or designee, could conduct routine audits to ensure appropriate care and services were implemented as ordered. The results of those audits could be taken to the QAPI committee for a determined amount of time to ensure compliance or the need for further monitoring.

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2 835	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 835		
2 995	MN Rule 4658.0610 Subp. 3 Dietary Staff Requirements -Grooming. 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. Findings include: During interview and observation of kitchen on 2/13/22 at 2:10 p.m., with certified dietary manager (CDM)-A, observed food items in the walk-in produce refrigerator and dry goods room that were not dated or marked and/or were expired. CDM-A indicated food production manager (FPM)-B typically went through all food	2 995	Corrected	3/15/23

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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 were stacked one on top of the other, top plastic food storage container lid had several white, dried areas, which resembled water spots.

During an observation with CDM-A, on 2/15/23 at 10:35 a.m., DA-A removed pan of skewered

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shrimp from oven, set pan on food prep table, grabbed thermometer from kitchen drawer, removed plastic cap from tip of thermometer, inserted tip of thermometer into skewered shrimp to temp shrimp, removed thermometer from shrimp, alcohol wiped tip of thermometer, set thermometer down on food prep table.

When interviewed, on 2/13/23 at 2:10 p.m., CDM-A indicated when food and beverage items were delivered to facility, staff would rotate food items, place older food items towards the front, newer food items towards the back, older food items to be used up first. CDM-A stated when food items were opened, staff were to mark date when opened so staff would be aware of when to discard items if beyond facility policy expiration date. CDM-A indicated staff should be checking fresh produce daily, if food appeared dry, discolored, had increased moisture, or was foul smelling, food should be discarded immediately.

During an interview, on 2/15/23 at 10:41 a.m., DA-A indicated would typically cleanse tip of thermometer with alcohol wipe prior to and after insertion of food when temping food.

When interviewed, on 2/15/23 at 10:47 a.m., CDM-A indicated all staff temping food should be cleansing tip of thermometer with alcohol wipe prior to and after insertion into food.

Facility policy titled Food Storage, reviewed date 11/22, consisted of; leftover food will be stored in covered containers or wrapped carefully and securely, each item will be clearly labeled and dated before being refrigerated, leftover food is used within 7 days or discarded per the 2017 Federal Food Code; all foods will be checked to assure that foods (including leftovers) will be

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consumed by their safe use dates, or frozen, or discarded.

Facility policy titled Covering, Labeling, and Dating of Food, reviewed date 11/22, consisted of; food items stored in the walk-in refrigerator and freezer will be covered, labeled, and dated by the cooks and dietary aides to ensure safety and proper rotation, all food items shall be discarded within 48-72 hours of labeled date, the Food Production Manager will inspect the walk-ins and freezer for uncovered, unlabeled or dates past due when major ordering is done 2x/week, cooks and dietary aides are also responsible to discard items as they see them or bring it to attention of the Food Production Manager.

FDA Food Code 2022, clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. 4-901.11 Equipment and Utensils, Air-Drying Required.
Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. 4-602.11 Equipment Food-Contact Surfaces and Utensils. Equipment food-contact surfaces and utensils shall be cleaned: before each use with a different type of raw animal FOOD such as beef, FISH, lamb, pork, or POULTRY; Each time there is a change from working with raw FOODS to working with READY-TO-EAT FOODS; Between uses with raw fruits and vegetables and with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD; Before using or storing a FOOD TEMPERATURE MEASURING DEVICE; At any time during the operation when contamination may have occurred.

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2 995	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate infection control technique is maintained in the kitchen. The facility could also ensure appropriate food storage occurs and dishware/utensils are dried under sanitary conditions. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 995		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19, when during a Covid-19 outbreak and high Covid-19 community	21385	Corrected	3/15/23

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transmission, residents, visitors and staff were observed not wearing appropriate personal protective equipment (PPE), specifically masks. This had the potential to affect all 211 residents who resided in the facility.

Findings include:

The facility was in outbreak status when R307, who was admitted on 2/3/23, tested positive for Covid-19 on 2/7/23, and was in transmission based precautions. In addition, the county community transmission level for Covid-19 was high.

During an observation on 2/13/23, at 3:30 p.m., observed two signs at the main entrance of the facility regarding visitor masking. Neither signs were on the door as individuals entered the facility. Both signs were laying flat, one on a credenza inside the main entrance and one on the receptionists desk. A visitor would need to stop and look for the signs in order to see/read them. The two signs dated 11/29/22, read: ATTENTION VISITORS AND GUESTS: Visitors to the Care Center are no longer required to complete a Covid-19 entrance questionnaire or temperature check when entering the building. However, we ask that you refrain from visiting if you are experiencing or have experienced any of the following: tested positive for Covid in the last 10 days, have Covid-like symptoms, have had close contact with a Covid-positive individual in the last 10 days. Currently visitors are asked to wear face coverings or masks when visiting residents as the Covid transmission level is HIGH in the surrounding community.

During an observation on 2/13/23, at 3:45 p.m., a sign was noticed on a wall entering the TCU

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(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 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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21385	Continued From page 17 (TC)-A stated resident masking had not been recommended for awhile, adding she did not encourage residents to wear a mask as she had not heard masking was required for residents...it was just mandatory for staff. -- On 2/15/23, at 11:47 (TC)-B stated she thought masking was a choice for the residents rather than mandatory and that it depended on the resident, as some did not understand why a mask was needed. TC-B stated she sometimes asked residents if they wanted a mask, but did not do it consistently. TC-B stated she had not heard the facility was in Covid-19 outbreak status. --On 2/15/23, at 1:32 p.m., R101 was who was in a wheelchair, self propelling in her third floor hallway near the dining room stated, "We don't need to wear a mask anymore." When asked if staff encouraged her to wear a mask when outside of her room, R101 replied, no, "They don't tell us to unless we're going to the doctor." According to quarterly Minimum Data Set (MDS) assessment dated 11/9/22, R101 was cognitively intact. -- On 2/15/23, at 1:52 p.m., R56 was resting in her recliner watching TV. R56 was asked if she knew if residents needed to wear masks when out of their room and replied no one had told her that, or had staff asked her to wear a mask outside of her room. According to admission MDS assessment dated 1/15/23, R56 was cognitively intact. -- On 2/15/23, at 3:40 p.m., R120 was walking in a resident hallway with her walker on second floor, on her way to play cards. R120 stated she didn't think she had to wear a mask anymore and, "Staff haven't reminded me." According to	21385		

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quarterly MDS assessment dated 12/28/22, R120 was cognitively intact.

-- On 2/15/23, at 3:53 p.m., R97 who was seen earlier on first floor in electric wheelchair with a mask on, and who was now in his room on his laptop stated, "I wear a mask if I'm on first floor, but not in the hallways up here. I haven't been told I need to." According to quarterly MDS assessment dated 12/14/22, R97 was cognitively intact.

-- On 2/15/23, at 3:57 p.m., R53 was in a resident hallway on third floor in his electric wheelchair, side by side with R87 who was also in a wheelchair. R53 was not wearing a mask and R87's mask was below his chin. R53 stated, "I don't think we have to wear masks, staff doesn't tell me to." According to quarterly MDS assessment dated 12/14/22, R53 was cognitively intact.

-- On 2/16/23, at 8:50 a.m., nursing assistant (NA)-D on third floor stated it was no longer required for residents to mask when out of their room; masks were only required for staff.

Observations and interviews of VISITOR masking:
-- On 2/14/23, at 3:48 p.m., family member (FM)-F was on fourth floor without a mask, on her way to the coffee shop on first floor. FM-F stated she didn't think visitors needed to wear a mask..."No one has told me I need to." FM-F stated if she should wear a mask, she would.

-- On 2/15/23, at 2:40 p.m., (FM)-G who was unmasked was observed in the hallway on fourth floor on his way to see R52. FM-G stated he never wore a mask; no one had told him he

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needed to but was not opposed to wearing a mask. FM-G visited R52 daily.

-- On 2/16/23, at 8:52 a.m., (FM)-H who was unmasked, was in the hallway on third floor at the nurses station talking to nursing assistant (NA)-D. FM-H stated he had not worn a mask in the facility for quite awhile...adding no one had told him he should. FM-H stated he wore a mask about 50% of the time when he came to to visit.

-- On 2/16/23, 9:03 a.m., main entrance receptionist (R)-I, when asked what her role was in visitor masking, stated she encouraged visitors to wear a mask if they asked, but understood visitor masking to be optional.

During an interview on 2/16/23, at 9:44 a.m., the DON stated the ADON-E had talked to him about visitor and resident masking. The DON stated they would do a little more to ask people to wear masks, adding they encouraged visitors and residents, but couldn't force them to wear masks. The DON was informed of observations and interviews of residents and visitors without masks.

During an interview on 2/16/23, at 10:43 a.m., the ADON-E was informed of observations and interviews of residents and visitors without masks. The ADON-E stated the way she interpreted the CDC and CMS guidelines, masking was not mandatory, even during Covid-19 outbreak status and during high community transmission. The ADON-E stated Covid-19 had been going on a long time and residents didn't want to wear masks anymore, adding many stopped taking Covid-19 boosters and they could see residents were sick and tired of it [Covid-19]. The ADON-E stated she had not

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re-educated residents on wearing masks and didn't know if anyone else had. The ADON-E admitted in her role, she would likely be the one to bring up re-education to the leadership team. The ADON-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 ADON-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., (ADON)-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 were not available at the back entrance. TMA-A 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 staff were required a mask prior to entering a

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21385	Continued From page 21 resident care area, and confirmed masks were unavailable to staff at the back employee entrance. Facility policy titled Covid-19 Infection Control Guidelines, with revised date of 2/13/2023, indicated the purpose was to provide guidance on the prevention of Covid-19 and to prevent and minimize exposures to respiratory pathogens. The Care Center would regularly monitor the CDC and CMS website's for the most up to date information and resources, and would adhere to guidance for visitation detailed within revised CMS Memorandum QSO 20-39 dated 9/23/22. The facility would utilize core principles of face covering or masking when permitting visitation to reduce the risk of Covid-19 and visitors would be given source control facemasks. PPE was used to protect staff and residents from the transmission of potentially dangerous and/or infectious pathogens. Face masks would be worn by all staff at all times when in resident care areas. Staff could momentarily lower their mask to access their mouths as needed (e.g. to take a drink). Staff should only lower their mask when a safe distance for others (e.g. 6 feet). SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits could be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring.	21385		

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21385	Continued From page 22 Time Period for Correction: Twenty-one (21) days.	21385		