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	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lyngblomsten Care Center	1415 Almond Avenue Saint Paul, MN 55108

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on observation, interview, and record review the facility failed to complete a safe transfer assessment for the use of sit-to-stand mechanical lift and follow manufacturer instructions and maintenance of the lift for 1 of 1 resident (R1) which resulted in a fall from the lift with a fracture. This resulted in an Immediate Jeopardy (IJ) for R1. The IJ began on [DATE], when R1 became tired and weak from standing in the lift while staff changed out two batteries and were unaware of the emergency lowering features which resulted in R1 letting go sustaining left arm fracture and left wrist tendon tear. The Administrator and director of nursing (DON) were notified of the IJ on [DATE] at 5:24 p.m. The IJ was removed on [DATE] after it could be verified that the facility had implemented an acceptable removal plan, however, non-compliance remained at D isolated severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R1's Diagnoses Report dated [DATE], Alzheimer's, dementia with behavioral disturbance, primary osteoarthritis (condition that affects the joints causing pain, stiffness, and reduced movement) of the right shoulder, anxiety, and was on hospice beginning ,d+[DATE]. R1's Minimum Data Set, dated dated dated [DATE], identified admitted ,d+[DATE]. R1 had moderately impaired cognition with inattentive and disorganized thinking, adequate hearing and vision, no behaviors, and required substantial staff assistance with all activities of daily living. R1's care plan dated [DATE], identified R1 had impaired physical mobility related to osteoarthritis in right shoulder, Alzheimer's, dementia with increased confusion, agitation, and history of delusions. Interventions included assist of one to transfer with the [WeStand]. Brand name of a sit-to-stand mechanical lift. R1's care plan dated revised [DATE], identified R1 had alteration in behavior related to Alzheimer's disease, dementia with behavioral disturbance, generalized anxiety disorder. R1's Behaviors included yelling, hitting, swearing, scratching, kicking, pushing, grabbing, threatening and calling staff names, and refusal with cares and medications. Interventions did not include what staff should do when R1 demonstrated those behaviors. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245347	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER Lyngblomsten Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 Almond Avenue Saint Paul, MN 55108	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's record did not include a comprehensive safe transfer assessment that identified the size and type of back belt/sling used for R1 when a mechanical lift was implemented. There was no mention of R1 had behaviors or mannerisms related to her diagnoses that could arise during sit-to-stand transfers using a mechanical lift. During an interview on [DATE] at 10:08 a.m., physical therapist (PT)-A stated they did not make recommendations for harness/sling size to use on residents. If a resident was not holding onto the stand or has their elbows in the air that would be a reason for nursing to get an evaluation to review the residents change. PT-A stated R1 discharged from therapy on [DATE] and was discharged using a WeStand for transfers. During an interview on [DATE] at 8:26 a.m., trained medication assistant (TMA)-C stated the care sheets (abbreviated care plan for direct care staff) only acknowledged a resident was a mechanical sit-to-stand or full body lift to transfer. TMA-C stated the slings are colored to identify the sizes, there was no height/weight guide on the slings or the lifts. TMA-C explained she knew which sling to use because she had been at the facility for many years and there everyday. During an interview on [DATE] at 9:04 a.m., nursing assistant (NA)-F stated the sling size was not on the care sheets. If a resident had elbows out and was not holding on to the stand properly or complaining of pain under the arms she would get a nurse to assess. NA-F indicated she had not worked with R1 and was not aware of sling size she used and/or R1's transfer ability. During an interview on [DATE] at 9:12 a.m., NA-G stated for standing lift transfers were not included on the care sheets. The sling/harness size was dependent on the size of the resident, sizes came in small, medium, and large. NA-G was aware what size slings resident required because she had worked with the residents before but would ask a nurse if she had to work with different set of residents. During an interview on [DATE] at 8:45 a.m., NA-E explained the sling sizes on the size of the resident, there was small, medium, and large. NA-E knew which sling size to use because it would already be in the resident's room. NA-E stated for the last six weeks when R1 was being raised in the lift, she would say enough, enough or No, staff would just wait a few minutes and try again. She [R1] never stands, she is always on the chair so you can imagine how her knees feel, so you would tell her a little bit more and she would go up a little bit more to get in the position to go to the toilet. NA-E did not articulate if the nurse had been notified or was aware of the difficulty R1 was having with these transfers. During an interview on [DATE] at 2:15 p.m., registered nurse (RN)-B stated sometimes R1 would have issues with transfers and would be quite behavioral; RN-B did not define or elaborate on what issues or behaviors R1 had. RN-B stated it was discussed with R1's family about using the full body mechanical lift, she could not remember how long ago the discussion. R1's family wanted R1 to continue to use the commode for toileting. RN-B explained, if R1 was a full body mechanical lift she would not be able to use the commode. Most of the time the floor staff would make her aware if someone was having difficulty with the WeStand lift, no one had reported to her any concerns with R1. RN-B did not know what she would do if a resident was stuck in the raised position mid-transfer; RN-B would probably have one person stay with the resident and the other one get a new battery. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Lyngblomsten Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1415 Almond Avenue Saint Paul, MN 55108	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:26 a.m., RN-C stated staff should be prepared and have all the equipment in position to make the transfer as quick as possible to minimize R1's time in the lift and to prevent and/or minimize R1's behaviors. If a resident was not weight bearing and hanging in the WeStand they would not be able to use the lift. The facility did not have an official assessment for the slings and staff go by the size of the person so it is not too tight or too big so staff can place the sling around them and adjust the seatbelt. During an interview on [DATE] at 3:17 p.m., director of nursing (DON) stated R1 had entered hospice care , d+[DATE]. The facility did not have a comprehensive safe transfer assessment for mechanical lifts, but nursing staff completed a significant change MDS and all assessments would have been completed during that time frame. DON was unsure if a transfer assessment had been completed since [DATE], even though R1 was on hospice and had been gradually declining and losing weight. During an interview on [DATE] at 3:32 p.m., family member (FM)-A stated R1 hated the WeStand, she always asked to get down. R1 would fight the staff and clench her arms. R1 always had her elbows up and extended outside the stand and never had the strength to hold on to the bars due to her osteoarthritis. FM-A stated about a month ago on R1's video camera they witnessed R1 hanging in the WeStand while staff cleaned the floor. FM-A provided the video to the facility but was not aware of who received it. FM-A reported when she was at the facility on [DATE], the lift stopped working during the transfer, staff left R1 in the lift while they got another battery. Then on [DATE], the same thing happened but R1 fell out of the lift and sustained injuries. FM-A stated since that incident occurred R1 had not been eating or drinking, however, some of that was happening before but after the injury she seemed to decline quicker. R1's progress notes dated [DATE], indicated after R1's shower staff were transferring R1 from the shower chair to the wheelchair with an EZ-stand. The EZ-stand got stuck in the standing position. In the middle of changing the battery, R1 pulled her left hand out of the sling and staff helped her down to the wheelchair. R1 complained of pain with the left arm with touch or activity, unable to grab, move, or even lift the hand. Updated house supervisor, family, and hospice. Got order for an x-ray of left arm. X-ray of two view of the left shoulder, hand and wrist completed at 1:30 p.m. R1's radiology result report dated [DATE] at 8:44 p.m., identified R1 had a minimally displaced fracture at the surgical neck of the left humerus (break in the bone of the upper arm). There is severe degenerative joint disease (deterioration of cartilage and bone) in the glenohumeral joint. The three-view x-ray of the left wrist shows widening of the scapholunate joint space consistent with ligamentous tear or laxity. R1's medical note from the physician dated [DATE], identified R1 has overall significant decline since injury and has been mostly sleeping, less interactive with staff and poor intake. R1's progress note dated [DATE], indicated R1 passed away at 12:30 p.m. on [DATE]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 1:50 p.m., NA-A stated he had been working on [DATE] and was involved in the incident with R1. NA-A stated he had just completed R1's shower and called trained medication aide TMA-A for assistance with transferring R1 with the lift. NA-A explained he did not feel comfortable transferring R1 alone because R1 was weak. NA-A thought R1 had been weaker for awhile. NA-A was unsure if nurses had been notified of the decline in R1's ability to transfer. NA-A explained when he and TMA-A were raising R1 in the mechanical lift the battery died . NA-A and TMA-A left R1 standing suspended in the lift by the back strap/sling while NA-A left the room to exchange the battery. The new battery did not work either so NA-A left R1's room again to get another battery; R1 continued to be suspended in the lift. NA-A indicated R1 then slipped out of the back strap/sling and landed in her wheelchair. They notified the nurse of the incident. NA-A stated there was something wrong with it [the lift] it had been having issues for a long time but was unaware if anyone had reported the issue or if the lift had been inspected. NA-A was not sure if the lift had been inspected after the incident on [DATE]. NA-A stated they did not use the emergency lowering mechanism on the lift to lower R1 once the lift stopped working. NA-A stated prior to the incident he had not been provided training on the WeStands and had been unaware of how to use the emergency stop or lowering mechanism. NA-A stated recently a similar incident with the battery not working during a transfer happened when R1's family was present and was not aware if a nurse was notified. During a phone interview on [DATE] at 3:54 p.m., TMA-A stated she had been working on [DATE] and was involved in the incident with R1. TMA-A explained R1 was raised in the WeStand and it would not go down. TMA-A tried to physically push the arms of the stand down and they would not move so NA-A changed the battery. TMA-A stated they needed to get two batteries from the charger. TMA-A stated R1 just let go; she slipped her right arm out of the sling which caused her to continue to slide out of the sling and falling into her wheelchair. TMA-A stated RN-A provided education to staff after the incident on how to lower the WeStand - I never seen that before. I have been trained but I did not remember. I usually work as a TMA. During an interview on [DATE] at 2:06 p.m., RN-A stated stated he had been working on [DATE] at the time of the incident. RN-A explained NA-A and TMA-A brought R1 to the nurse's station. They reported when they had transferred R1 from the shower chair to the wheelchair. R1 was stuck on the WeStand in the raised position and when they were tried to lower her the machine stopped. They tried to get a replacement battery but R1 was trying to get out of the sling, they managed to lower R1 to her wheelchair. RN-A had asked if NA-A and TMA-A if they used the manual release to lower R1 when the machine stopped and both staff reported they had pressed the emergency button but it did not work. RN-A stated the two staff were showed the emergency stop button that they pressed, not the emergency release button. After the incident RN-A stated R1 was unable to grab RN-A's hand and unable to raise her arm. RN-A notified hospice, family, and supervisor. RN-A mobilized R1's arm and gave R1 pain medications for comfort and ordered an x-ray. RN-A took the WeStand and placed it behind the nurses station. RN-A used the same WeStand to demonstrate to staff who were working on R1's unit on how to use the lifts emergency functions and had them do return demonstrations. RN-A stated he put on his report sheet for the following shift the WeStand needed to be checked by maintenance. RN-A was unaware of any specific numbers used to identify the machine or batteries that had been used and did not work. She was unsure if the lift he had removed or inspected by maintenance before it was used again. During an interview on [DATE] at 2:00 p.m., NA-D stated prior to the incident she had not been trained on the emergency features on the WeStand. After the incident with R1, RN-A provided education with return demonstration. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:17 a.m., NA-B stated she was unaware of that there was battery indicator light on the WeStand machines. NA-B stated if the battery stopped working while a resident was standing on the lift, she would leave the resident standing and have another staff watch the resident while she got a new battery. During an interview on [DATE] at 1:20 p.m., assistant director of nursing (ADON)-A reviewed that the WeStand distributor (WE)-A had been at the facility for about a week beginning [DATE] providing training on the new lifts. Staff would need education yearly on the lifts during their annual reviews and ADON-B kept track of those. ADON-A stated RN-A educated the four staff working on R1's unit after the incident. Then the house nurses educated staff on the manual release but neither of those education opportunities were documented. During a phone interview on [DATE] at 12:39 p.m., WeStand representative (WE)-A stated he was not notified of R1's incident with the lift until [DATE]. WE-A stated the batteries need to charged for eight hours to have a full charge but that a person could use the battery after an hour of charging, however it wouldn't last very long. WE-A recommended to switch the batteries out at the end of each day to ensure proper charge time. The batteries do not have any memory so the more you charge them the better they are. WE-A stated he was at the facility a few days ago to go over how to fix the issue with the remotes being pulled from the machines. During a subsequent interview on on [DATE] at 4:47 p.m. WE-A reviewed emergency procedures. The emergency red handle on the actuator (arm) of the stand is what a person would lift up to lower a resident. The secondary emergency lowering button would require a pen/pencil tip to poke it and cause the motor to lower the person. Only one emergency lowering mechanism is needed to lower the person, both are not needed to be activated together. There is a battery indicator on the back of the control box that shows how many bars are left in the battery and when the plug shows that means it needs to be put on the charger. WE-A stated if a resident is not using upper body strength and/or has behaviors they should not be using the sit-to-stand machine, staff should not rely on the back belt/sling to hold a resident. During an interview on [DATE] at 10:33 a.m., maintenance director (MAD)-A stated he had just heard about the incident with R1 that occurred on [DATE] just this morning ([DATE]). MAD-A stated the maintenance department was trained to service the lifts. They have had two lifts serviced recently for repairs and could only assume one of the lifts was the one from the incident, as the nursing staff always moved the lifts around the units. The two lifts that were serviced needed to have the remote zip tied because the cord for the remote was being pulled out and losing power to the machine. MAD-A stated there were serial numbers on each lift for them to be tracked, however, this was not completed. MAD-A did not have a system in place to monitor the batteries for the lifts but there was one extra battery for each lift on each neighborhood. MAD-A stated the WeStand representative gave all the in-services for the staff on the equipment he sells and distributes. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:06 a.m., director of nursing (DON), ADON-A, and ADON-B the DON stated prior to getting the WeCare lifts [DATE], the old lifts had battery issues. Staff were used to running and grabbing a battery during a transfer. DON stated at some point NA-A and TMA-A should have used the lowering mechanism to lower R1 to the wheelchair. DON stated NA-A and TMA-A were not able to problem solve of what action to perform first and were trying to do the quickest and most safe thing in their minds. DON stated the harness and sling size were pretty standard and come in different sizes. When the WeStand representative provided initial training last June, he said 90% of residents would use an adult size large. The slings were adjustable by colored loops based on the size of the individual. R1 used adult size large sling. After R1's incident on [DATE], the staff did not make comments about the sling being in disrepair or frayed so it was not examined. DON was unsure which WeCare lift was used for the transfer but thought MAD-A would have known. The facilities Safe Assisted Resident Transfers policy revised ,d+[DATE], identified that stand assist lift (EZ-stand): one staff use assistive device to provide moderate to maximum assist in lifting resident. Resident must be able to bear some weight, participates by following direction and holding onto hand grips. May need two staff if resident needs high level of cueing or has behaviors. The WeStand operating lift manual dated ,d+[DATE], identified that before using the WeStand to transfer patients, all staff must be trained and authorized to use the WeStand. A DVD demonstrating transfer techniques and WeStandTM care was sent to the facility with the lift. This DVD can be used, along with hands on training led by a nurse or professional rehabilitation staff member who has been designated as your facility's mechanical lift trainer, as part of your facility's mechanical lift education program. Only staff members who have been trained according to the procedures in this manual, by a manufacturer's representative, or by a nurse or professional rehabilitation staff member designated as your facility's mechanical lift trainer, be allowed to use the WeStandTM. Watching the DVD without hands on training DOES NOT QUALIFY AS TRAINING. Staff members who have seen the DVD but who have not had hands on training described above may not use the WeStandTM. Before using the WeStandTM, patients must be assessed by the facility's professional nursing or professional rehabilitation staff to determine which patients are suitable for transfer with the WeStandTM, which WeStandTM transfer technique to use, which size belt/sling is appropriate, and the number of staff members necessary to transfer each patient. Although one person can perform patient transfers, certain patients or situations may require the help of one or more additional staff members. For example, patients with unpredictable behavior due to dementia may require additional help if their behavior poses risk of injury to themselves or to staff members. Patients Not Suited For WeStandTM Standing Transfers 1) Patients whose unpredictable behavior during transfers poses risk of injury to patients or staff. Examples are patients who: a) Attempt to pick one or both feet off of the floor during gait belt transfers or off of the WeStandTM foot pad during WeStandTM standing transfers b) Attempt to climb the knee pad c) Attempt to step backward off of the WeStandTM foot pad (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d) Are unpredictably able to bear weight e) Frequently exhibit combative behavior during transfers f) Are unable to follow simple directions The IJ was removed on [DATE] when the facility inspected all lifts, belts, and slings for function and safety and removed from service any that were out of compliance. The facility reassessed all residents who utilized mechanical lifts with a comprehensive assessment and updated care plans and care sheets for staff. A routine maintenance program was developed and implemented following manufacturer guidelines with monthly and annual lift inspections. The facility reviewed and/or developed policies for stand assist and full lift transfers. The facility developed policies that define procedures for the assessment/re-assessment of resident transfers. Facility staff were trained on all procedures.