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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DDR0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00945

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245394**

2.STATE VENDOR OR MEDICAID NO.
(L2) **914342400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE ESTATES AT LYNNHURST LLC**
(L4) **471 LYNNHURST AVENUE WEST**
(L5) **SAINT PAUL, MN** (L6) **55104**

4. TYPE OF ACTION: **2** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2017**

6. DATE OF SURVEY **12/15/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **70** (L18)
13.Total Certified Beds **70** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 01/03/2022 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 01/03/2022 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/14/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2022

CMS Certification Number (CCN): 245394

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

Dear Administrator:

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

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

Effective December 1, 2021 the above facility is certified for:

70 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 70 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically Delivered
January 3, 2022

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: CCN: 245394
Cycle Start Date: October 14, 2021

Dear Administrator:

On December 15, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: DDR0

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3. Termination 4. CHOW
5. Validation 6. Complaint
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8. ACCREDITATION STATUS: __ (L10)
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FISCAL YEAR ENDING DATE: (L35)
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	70			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Pete Cole, HFE NE II 11/15/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 12/03/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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12/01/1986
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23. LTC AGREEMENT BEGINNING DATE
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25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
November 4, 2021

Administrator
The Estates At Lynnhurst LLC
471 Lynnhurst Avenue West
Saint Paul, MN 55104

RE: CCN: 245394
Cycle Start Date: October 14, 2021

Dear Administrator:

On October 14, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Sarah Grebenc, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: sarah.grebenc@state.mn.us
Office: (651) 201-3792 Mobile (651)238-8786

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 14, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 14, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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, Health Program Representative Senior
Program Assurance | Licensing and Certification
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
	245394	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

(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 10/11/21, through 10/14/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan	E 004		12/1/21

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

Electronically Signed | 11/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ESTATES AT LYNNHURST LLC	471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104

(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 004	Continued From page 1 that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to review the Emergency Action Plan (EAP) annually in accordance with the requirements of CFR 483.73. This had the potential to affect all 45 residents currently residing in the facility. Findings include: The facility EAP revised 9/2/2020, under Signature, indicated, The executive director and	E 004	All residents have the potential to be affected by the facility failing to review and update the Emergency Action Plan annually. Immediate Corrective Action: The Administrator will review the Emergency Action Plan. Action as it applies to others:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 004	Continued From page 2 the Emergency Management Committee will review the entire plan annually and revise as necessary. The last documented review of the EAP was on 9/2/2020. When requested the facility did not provide documentation of a review that had been done in the last year. During interview on 10/12/21, at 11:12 a.m. administrator verified the facility had not performed and documented a review of the EAP during the last year.	E 004	The facilities policy and procedure for maintaining the Emergency Action Plan remains current. The Administrator and appropriate IDT/Facility Staff will review the Emergency Action Plan by December 1, 2021. Facility will document that the Emergency Action Plan has been reviewed and remains current. Recurrence will be prevented by: Administrator/Associate Administrator will be educated on the federal requirement to review the Emergency Action Plan annually. The Correction will be Monitored by: Administrator/ Associate Administrator/Designee	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:	E 037		12/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING _____ B. WING _____	C 10/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 037	Continued From page 3 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE ESTATES AT LYNNHURST LLC	**471 LYNNHURST AVENUE WEST SAINT PAUL, MN 55104**

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E 037	Continued From page 4 procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.	E 037		

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	245394	A. BUILDING _____ B. WING _____	C 10/14/2021

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E 037	Continued From page 5 *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 6 *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide required training in emergency preparedness policies and	E 037	All residents have potential to be affected by the facility failing to educate all staff on the facility specific Emergency Action	

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E 037	Continued From page 7 procedures that was specific to the facility and was consistent staff's roles in an emergency to all new and existing staff, individuals providing services under arrangement, and volunteers. This had the potential to affect all 45 residents residing in the facility. Findings include: Document review revealed the annual emergency preparedness training had been completed using a general on-line module from their learning management system, Healthcare Academy, entitled Annual Federal Training Summary. The learning objectives in this module did not demonstrate training in facility specific emergency preparedness policies and procedures consistent with their expected facility specific roles in an emergency. In addition, four out of six staff sampled received no emergency preparedness training during the last year. Those staff included, registered nurse (RN)-A, nursing assistant (NA)-B, therapeutic recreation (TR)-A and culinary services assistant (CSA)-A. During interview on 10/13/21, at 2:41 p.m. RN-A stated she did not recall taking emergency preparedness education that was specific to the facility during the last year. During interview on 10/13/21, at 2:48 p.m. licensed practical nurse (LPN)-A stated in the past the facility had used an emergency preparedness module from Healthcare Academy that was not specific to the facility's emergency preparedness plan and did not recall taking documented education on emergency preparedness during the last year.	E 037	Plan. Immediate Corrective Action: staff will be educated on the facility specific emergency plan by December 1, 2021. Action as it applies to others: The facilities Policy and procedure for educating staff on the facility Emergency Action Plan remains current. An audit will be completed to ensure staff have been educated on the facilities Emergency Action Plan. Ongoing monitoring will be dictated by the QAPI team based on the results of the audits. The Correction will be Monitored by: Administrator/ Associate Administrator/Designee	

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E 037	Continued From page 8 During interview on 10/13/21, at 11:05 a.m. administrator stated emergency preparedness education had not been assigned to all staff during the last year and the facility did not have documentation of emergency preparedness education for the staff requested from the sample. Emergency Action Plan, revised 9/2/2020 did not include a policy or procedure for staff emergency preparedness education or frequency of education.	E 037		
F 000	INITIAL COMMENTS On 10/11/21 through 10/14/21, a standard recertification survey was conducted at your facility. In addition, complaint investigations were conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5394137C (MN51180 and MN51230) with no deficiency cited. H5394138C (MN77428) with no deficiency cited. The following complaints were found to be UNSUBSTANTIATED: H5394131C (MN77321) H5394132C (MN76663) H5394133C (MN75778) H5394134C (MN68472) H5394135C (MN64376)	F 000		

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F 000	Continued From page 9 H5394136C (MN59436) The facility's plan of correction (POC) will serve as your allegation of compliance upon the 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 substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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.	F 609		12/1/21

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F 609	Continued From page 10 §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 report timely to the State Agency (SA) a vulnerable adult who left the facility against medical advice (AMA) for 1 of 1 residents (R37) reviewed for abuse allegations. Findings Include: The Monarch Healthcare Management policy, Abuse Prohibition/Vulnerable Adult Plan dated 8/26/21, directed staff to ensure that all incidents of alleged or suspected neglect were promptly reported. The policy further directed, if a vulnerable adult discharges from the facility against medical advice, all discharges that were against medical advice need to be reported to MAARC (Minnesota Adult Abuse Reporting Center) within 24 hours. R37's diagnoses included paranoid personality and anxiety obtained from the Admission Record printed 10/13/21. R37's quarterly Minimum Data Set dated 9/17/21, indicated R37 had intact cognition and was independent with activities of daily living. R37's care plan dated 3/24/21, indicated R37 was to discharge back to his home. The care plan further indicated R37 was at risk for abuse and	F 609	All residents have the potential to be affected by the facility failing to report timely to the State Agency a vulnerable adult who left the facility against medical advice (AMA). Immediate Corrective Action: Facility immediately completed MAARC report for when R37 left AMA from the facility. Action as it applies to others: The facilities policy and procedure for Abuse Prohibition/ Vulnerable Adult Plan remains current. staff will be re-educated on the Abuse Prohibition/ Vulnerable Adult Plan. Recurrence will be prevented by: Associate Administrator/Social Services Director/Designee will audit all OHFC/ MAARC reports to ensure they are being reported to the correct state agency and in accordance with the facilities policy and procedure. Results will be shared with facility QAPI committee for input on the	

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F 609	Continued From page 11 neglect and staff were to follow the facility vulnerable adult and abuse policy. R37's electronic medical record (EMR) had a social services note dated 10/8/2021, at 3:52 p.m. indicated R37's physician was updated regarding R37 refusing medications and frequent threats of killing other residents and staff. An order was received for R37 to be sent to the hospital for a psychological evaluation. A phone call was placed to local police. R37's EMR had a nursing note dated 10/8/21, at 7:00 p.m. indicated R37 returned to the facility (R37's whereabouts unknown) at 5:40 p.m., 911 was called and three policemen arrived in the facility. R37 refused to go to the hospital and stated that he would rather discharge from the facility than to go to the hospital. The nursing note further indicated the director of nursing (DON) attempted to encourage R37 to go to the hospital to receive adequate care but R37 declined and stated "I would rather leave." R37's EMR had a nursing note dated 10/9/21, at 6:05 a.m. indicated R37 was discharged from the facility on 10/8/21. During an interview on 10/13/21, at 8:37 a.m. the administrator in training, administrator and social services director, indicated Associated Clinic of Psychology (ACP) therapist recommended R37 go to the hospital for an evaluation. During the interview, social services director indicated a MAARC report was not made when R37 left AMA from the facility.	F 609	need to increase, decrease, or discontinue audits. The Correction will be Monitored by: Associate Administrator/ Social Services Director	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		12/1/21

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F 677	Continued From page 12 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide assistance with oral care for 1 of 2 residents (R6) reviewed for Activities of Daily Living (ADL). Findings include: R6's quarterly Minimum Data Set (MDS) dated 7/7/21, indicated R6 was cognitively impaired, extensively dependent on staff for personal hygiene and had no functional limitation in range of motion to both upper extremities. R6's care plan last revised 7/16/21, identified R6 received extensive assist with personal hygiene. On 10/11/21, at 1:15 p.m., R6 indicated the staff did not brush her teeth. R6 indicated missing teeth, but not receiving any oral care in the morning or evening. During observation on 10/13/21, at 7:43 a.m., nursing assistant (NA)-C completed R6's morning activities of daily living that included, catheter cares, bathing, grooming, dressing and transferring R6 into the wheelchair. No oral cares were completed. During interview on 10/13/21, at 8:18 a.m., NA-C indicated the cares on the nursing assignment sheet were the cares she completed. Review of the NA Group 2 report sheet indicated "ADLs: EA	F 677	All residents who are dependent on staff for assistance with oral care have the potential to be affected by the facility failing to aid with oral care. Immediate Corrective Action: R6 dental referral reviewed from 3/17/21 and recommendations added to ADL sheet when to provide oral cares for R6. R6 Oral care was provided by CNA with soft toothbrush and fluoride toothpaste for 2 minutes on 11/5/21. R6 has been provided with a personal soft toothbrush, fluoride toothpaste, and a basin. R6 care plan has been updated with tasks for oral care to be provided twice daily with soft toothbrush and fluoride paste. Action as it applies to others: The facilities policy and procedure for Activities of Daily Living was reviewed and remains current. nurses and nursing assistants will be re-educated on policy and procedure for ADL care/oral care including the new process by director of nursing or designee/Designee. Recurrence will be prevented by:	

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F 677	Continued From page 13 1" (activities of daily living: extensive assist of one). During interview on 10/13/21, at 8:34 a.m., The director of nursing (DON) indicated the expectation would be assist with oral cares, even if not on report sheet. The DON also indicated when a resident returns from a dental appointment, and brushing was recommended, it would be added to the nursing assistant assignment sheet. It was the responsibility of the nurse manager to add to the assignment sheet, if no manager, then the assistant DON or the DON. Observation on 10/13/21, at 9:17 a.m. NA-C brought R6 to her room. NA-C opened a new toothbrush and brought in new emesis basin, new toothbrush holder, and new box with a tube of toothpaste. NA-C asked R6 is she wanted to brush her own teeth and R6 requested the NA complete it. NA-C brushed R6's teeth (it was noted that R6 has one upper tooth and 4 or 5 lower teeth) After staff left, resident indicated her teeth hadn't been brushed for a long time," like over a month." Review of R6's record revealed MDS 3.0 Oral/Dental Assessment Form dated 3/17/21, which was signed by a dental assistant, indicated obvious or likely cavity or broken natural teeth. [R6] needed direct staff assistance, and to brush teeth each morning and evening, brush teeth and gums for approximately two minutes, as tolerated, using a soft toothbrush and fluoride toothpaste. Review of the facility Activities of Daily Living (ADLs) policy revised March 2018 indicated: 2. Appropriate care and services will be provided	F 677	To monitor performance and ensure solutions are sustained, the Director of Nursing or designee will audit oral care on 3 dependent residents 3x per week for 4 weeks then 1x per week for 3 months until compliance is sustained. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The Correction will be Monitored by: Director of Nursing/ Designee	

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F 677	Continued From page 14 for resident who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming and oral care).	F 677		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 rooms were maintained in good repair and in a functional manner. This had the potential to affect 4 residents (R39, R42, R35 and R13) who resided in the rooms reviewed for environmental concerns. Findings include: On 10/12/21, at 2:16 p.m. in R39's room a dresser was observed with one pull handle on a drawer partially attached and one pull handle missing on another drawer on R39's dresser. During interview on 10/12/21, at 2:16 p.m. R39 stated the drawers had been the observed state of disrepair since she was admitted to the room "a couple years ago." R39 stated, "I keep saying something to maintenance about this and nothing ever gets done." R39 stated the broken handles on her dresser made it difficult for her to use.	F 921	All residents have the potential to be affected by the facility failing to maintain a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Immediate Corrective Action: Facility maintenance team immediately identified and fixed building concerns for residents R39, R42, R35, and R13. Action as it applies to others: The facility will develop a policy and procedure for staff to enter building repairs into our integrated life safety, asset management, and Maintenance solutions program, TELS. staff will be educated on how to enter work orders into TELS. Maintenance Director/Designee will be educated on	12/1/21

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F 921	Continued From page 15 On 10/12/21, at 2:10 p.m. R42's room was observed to have a dresser drawer missing two pull handles. On 10/12/21, at 2:23 p.m. R35's room was observed to have a dresser drawer missing a pull handle. On 10/12/21, at 3:14 p.m. R13's room was observed to have a dresser drawer missing a pull handle. During interview on 10/13/21, at 2:00 p.m. licensed practical nurse (LPN)-A stated whenever staff noticed a room in disrepair they would enter it into the TELS (computer work order software) system and the facility maintenance department was expected to respond to the TELS notification. During interview on 10/13/21, at 2:17 p.m. nursing assistant (NA)-A stated when direct care staff notice a room in disrepair they enter it into the TELS system. During interview on 10/13/21, at 3:12 p.m. maintenance director (MD) stated the facility maintenance department is notified of disrepair in resident's rooms through the TELS system and then the repair was expected to be performed. During interview on 10/13/21, at 11:13 a.m. regional maintenance director (RMD) stated the facility had become aware of the rooms in disrepair only during the week of the survey. RMD stated the previous maintenance director had not been able to prioritize repair work that required and attention and complete it. RMD stated there were not work orders for R42, R39, R35 and R13's rooms prior to the start of the survey.	F 921	completion of work orders within TELS. The Maintenance Director/Designee will be responsible for monitoring and completing all work orders that are entered into TELS. Recurrence will be prevented by: Environmental tours completed by the Associate Administrator and Maintenance Director and/or Designee will occur weekly x4 weeks, then monthly x12 to ensure building repairs are identified. All building repairs will be entered into TELS. Associate Administrator/Designee will audit TELS to ensure work orders are being completed in a timely manner. Results will be shared with facility QAPI committee for input on the need to increase, decrease, or discontinue audits. The Correction will be Monitored by: Maintenance Director/ Associate Administrator/Designee	

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F 921	Continued From page 16 During interview on 10/13/21, at 3:24 p.m. administrator stated the facility did not have TELS reports that indicated R42, R39, R35 and R13 had furniture in their rooms that was in disrepair. During interview on 10/14/21, at 10:19 p.m. administrator in training (AIT) stated the expectation was for all staff to report resident's rooms that were in disrepair through the TELS system and for maintenance work to then be done in a timely fashion. AIT explained when a repair order was entered into TELS the facility maintenance director got the order and it was also reviewed in the facility daily stand-up meeting for repair. AIT stated the facility did not have a policy or procedure for entering work orders or for the maintenance department's response to work orders that were submitted for resident's rooms.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245394	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/14/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/14/2021. At the time of this survey, The Estates at Lynnhurst was found 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, the Health Care Facilities Code. The Estates at Lynnhurst is a 2-story building with a partial 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 1967, an addition was constructed to the northeast and was determined to be of Type II(222) construction. Because the original building and the one addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 70 beds and had a census of 48 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a), is MET.	K 000		

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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